Knowsley Safeguarding Children Board

A Serious Case Review
Overview Report

Final Version

CHILD Q & CHILD S

13th December 2016

Abbreviations.

Police Force	Local Authority Area (LA)
Police Force 1 covers	LA 1, 2, 6 (LA2 is the Local Authority Area with responsibility).
Police Force 2 covers	LA3.
Police Force 3 covers	LA4.
Police Force 4 covers	LA5.
CAMHS	Child and Adolescent Mental Health Services.
CSE	Child Sexual Exploitation.
CIN	Child in Need.
MASH	Multi-Agency Safeguarding Hub.
CAF	Common Assessment Framework to be known as the Early Intervention Process.
LAC	Looked After Children
LSCB	Local Safeguarding Children's Board.
SIRG	Serious Incident Review Group.
SARC	Sexual Assault Referral Centre.
Probation Services	National Probation Service (NPS) manages high risk of serious harm and MAPPA eligible cases.
Community Rehabilitation Company	Community Rehabilitation Company (CRC) provides local probation services in the community directed at low to medium risk of harm offenders.

SECTION 1: FOREWORD.

1. ***Copyright.***
This report was authored by Jane Carwardine (Independent Reviewer), its content has been quality assured by the Serious Case Review Team, Serious Incident Review Group (hereinafter known as the SIRG) and the Local Safeguarding Children's Board (hereinafter known as the LSCB). It is owned by and copyright remains with the LSCB. The review has been written in a way to protect the identity of the children, professionals, organisations and areas. The rationale for this decision is explained within the content of the review. The Local Authority Area (LA2) has statutory responsibility for both children.

2. ***Communications with the Serious Case Review National Panel of Independent Experts on Serious Case Reviews (hereinafter referred to as the National Panel)*.**
This serious case review has been commissioned by the LSCB (LA2). Negotiations have been undertaken with the National Panel in respect of two issues. The National Panel disagreed with the LSCB's initial decision, to undertake a multi-agency learning review in respect of Child Q. This decision was reviewed by the LSCB and the original decision amended considering the National Panel's advice.

3. The case of Child S emerged whilst the Child Q case was under review. The LSCB planned to combine the learning from both cases into one serious case review. The view of the LSCB and its membership was the planned methodology would increase the opportunity for learning, in respect of the local arrangements to manage Child Sexual Exploitation (hereinafter known as CSE). The National Panel challenged the methodology because whilst other national reviews have used a combined methodology, the features of these cases, in respect of the offender profile is different. The LSCB, Case Review Team, Independent Reviewer and the Legal Advisor considered the National Panel's response. The methodology was adapted to consider the children's experience, the analysis and practice issues separately, whilst the combined learning and conclusion would provide a thematic overview. Agreement was reached to continue with the original LSCB decision. The grounds being the methodology would provide an improved opportunity for learning, in respect of how the local systems and practice support improved outcomes for children at risk of CSE. In addition, the review process was near completion at the time the National Panel responded to the request. A methodology change would have resulted in a delay in completion, caused a postponement in a planned learning event, created a significant delay in appreciation of the learning and incurred a significant additional financial cost from the public purse.

4. ***Equality and Diversity Considerations.***
The review of these cases highlights several issues related to diversity and equality which are referenced within the content of the review. The use of the term "*Child*" throughout the review is used intentionally to make the reader consider that child abuse and neglect including CSE can impact on all children irrespective of gender, race, culture, disability and/or sexual orientation. The impact on the child is devastating and can be catastrophic in the longer term unless adjustments are made in the provision of preventative and restorative services.

5. The child's behaviours are frequently both reflective of how they adapt to their situation and are a defence mechanism to enable them to cope. Too often the child's behaviour becomes the focus of blame rather than managing the abuse they have had to or continue to endure. Unfortunately, these children are often perceived in society as the most troublesome children, sometimes resulting in criminalisation which impacts negatively on their future life chances for good health, education, socialisation and employment. They are the most troubled children in

society, who need not only our empathy but long term, consistent, specialist support to recover and lead a fulfilled life. Their childhood journey through to adulthood will be more difficult than their counterparts yet frequently they must do this alone without a consistent or supportive parental figure.

6. Children looked after as a minority group are known to have some of the poorest health, social and educational outcomes and therefore this becomes a double, triple or quadruple jeopardy when they are also victims of CSE. They require but often don't receive the opportunities available to the whole child population due to a complexity of reasons. These children require adjustments to be made in the provision of services to ensure their recovery in the long term.

7. The offender profiles discussed within these cases are different when considered in the context of other recent national serious case reviews[1]. In Child Q's case the offenders were older white British adult males, who were intent on forming inappropriate relationships with the child, either through direct contact or indirect contact. In Child S's case the investigations have been focussed on younger British males (aged 14 years and 19 years). There was no evidence that the abuse was organised or because of social media networking. This enhances the perspective that adults who commit offences related to CSE cannot be ascribed to one community, age, cultural group, gender or sexual orientation. The profiles of offenders can differ resulting in different forms of CSE which may overlap and interact. Some models such as "*the older boyfriend"* may be misinterpreted as an acceptable relationship. The disruption of such activity requires ongoing vigilance and investigation across the population and is not the sole responsibility of one agency or professional group. Professional assumptions can be made that the child is a willing participant but should always be the victim, because of the power imbalance and potential or perceived threats. It is also notable that the internet was a key source for the subversive grooming in both cases which also sets these cases apart from many of those in the media.

8. ***The Serious Case Review.***

The background to and the methodology followed for this serious case review is contained within appendix 1. Several learning points were identified during the serious case review process which would improve the process for future reviews;

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.

Learning Point 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.

Learning Point 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.

[1] Bedford A., (2015). Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of children A, B, C, D, E, and F. Approved by the OSCB February 26th 2015.

9. ***Thanks.***

The Independent Reviewer would like to thank the children and their families for their insightful participation in the review process and the practitioners and managers who reflected and shared their experiences whilst working with Child Q, Child S and their families. Their contributions were extremely advantageous to the review process, enabling enhanced learning. The motivation and passion of front-line professionals, to make a difference to the lives of the children at the time of their involvement, was evident throughout the review process. The LSCB is grateful for the challenge provided by the National Panel and welcomes the opportunity this triggered for reflection on its decision-making processes.

SECTION 2: CHILD Q SERIOUS CASE REVIEW.

2.1 Child Q: A Synopsis.

10. ***A Portrait of Child Q.***
Practitioners involved in the provision of care for Child Q have consistently and warmly described the child as endearing, lovely and extremely enthusiastic. Child Q was always keen to engage in new activities and, would put considerable energies into developing new skills, loving outdoor activities. Child Q was keen to always maintain a good appearance whether in school uniform or normal clothes. This child was described as one of the "*smartest children*" in school, having special skills with younger children, being very caring and demonstrating a good understanding of their needs. Child Q was academically bright, achieving above average attainments in Mathematics, English and Science. Child Q could at times present with significant behavioural difficulties, which is likely to be an effect of living with long term abuse and neglect, insecure attachments, loss and bereavement and placement instability. Child Q was noted to be very streetwise exhibiting no demonstrable fear of unknown situations.

11. ***A Summary of Child Q's Life.***
In 2002, 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. The extended family networks offered support to the family. The youngest sibling was born during the period of child protection intervention in 2008. The concerns documented at the time were as follows; 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.

12. In 2006, the family moved from LA1 to LA2, with a known history of neglectful parenting. Child Q was 4 years old. Despite a period of early intervention, neglectful parenting persisted, with only intermittent and temporary improvements in the care the children received. 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 (12 documented placements), eventually being placed in a Specialist Residential Children's Home. Unfortunately, the eldest sibling died suddenly and unexpectedly. This bereavement had a devastating impact on Child Q and the family. Child Q remained very unsettled and clearly distressed at times partly due to the loss, exhibiting extremes of challenging behaviour and frequent missing from care episodes.

13. The family strengths were that the children were clearly loved by their parents and family which was reciprocated by the children. Child Q's attachment to the birth parents was disorganised [2] and Child Q had an intense desire to remain in contact with her family whilst looked after by LA2. Several of the missing from care episodes were linked to the desire to return and see family members and the grandmother especially when planned contact arrangements were unsuccessful.

[2] See glossary for definition of disorganised attachment.

14. ***Child Q: The Trigger Event (12 years 10 months**).*
In December 2014, Child Q was looked after by LA2, in a cross boundary local authority area (LA5). At that time, Child Q was placed in an Independent Specialist Multi-Occupancy Residential Children's home (LA5) and was 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 Force 4 and the Residential Care Workers (LA5) to manage the risk of CSE. This included keep safe work and searches for additional mobile devices.

15. 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. Offender disruption strategies were underway at the time of this event. The following weekend, Child Q (aged 12 years), 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 at 7pm on the evening of the second missing episode 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 8 30 pm. 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 near 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 arrived at 8 15 pm and were informed the child had left ten minutes previously. The Police Force's (4) expectation was that Child Q would not be left unsupervised, as part of the risk management strategy.

16. Following an immediate local search by the carers, the episode was reported to Police Force 4 and graded as high risk. Immediate enquiries to trace Child Q ensued and the child's known mobile number was cell cited in LA1. Further investigations including observing closed-circuit television led to further enquiries in LA1. This resulted in the identification of a witness who provided the Constabulary with details of a second unknown mobile device in use by Child Q. Subscriber checks were undertaken on this second mobile device which led to the arrest of an older male, a known registered sex-offender. Further cell citing checks of the second mobile device resulted in Child Q being traced to a friend's home, in bordering LA1.

17. 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.

18. Child Q is now placed in a lone, out of area placement with two carers, due to complex difficulties in securing stability in at least three differing placements following the incident. Child Q is now reported to be gradually responding to the behaviour management strategies and care arrangements, having had to accommodate significant challenges and more insecurity in placement stability. Placement stability has only recently been achieved. 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. Child Q has also recently responded to and enjoyed contact with birth parents and younger siblings which was reported as a positive experience for the child.

Good Practice Point 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.

2.2 Child Q's Story: A Chronological Analysis.

19. This section provides a chronological analysis which includes Child Q's story and an analysis of the most significant events and themes. The timeline reviewed is between January 2013 and February 2015. A historic perspective of relevant issues and themes is also provided. Good practice and learning points are identified throughout the text.

20. ***Child Q: The Retrieval of Historic Information.***
Child Q's family had resided in the responsible authority area (LA2) for several years and were well known to the multi-agency professionals. During practitioner conversations, local practitioners understood the context of the child's experience in relation to historic long term abuse and neglect. The devastating impact of the abuse on the child was a significant consideration. The systems enabled Children's Social Care to retrieve relevant historic records and this was generally shared with multi-agency partners when necessary.

21. Nationally there have been significant concerns in respect to the retrieval of historic information in the management of abuse cases. In this case, best practice was achieved by Children's Social Care in respect to the retrieval of historic information. This is crucial in practice when managing the impact of CSE on children who have a longstanding history of neglect, abuse and trauma. It helps prevent professionals from considering the issues from a linear methodology and avoids the use of reductionist theories[3] which simplify the complexity and impacts of child abuse on the child.

22. ***Child Q: Information Sharing*****.**
There is considerable evidence during the transition of care to the cross-boundary area (LA5) relevant information was shared effectively with most key local agencies to influence multi-agency working arrangements. The key Social Worker was extremely influential in the arrangements and this was commended by multi-agency colleagues.

Good Practice Point 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.

23. Information sharing with cross boundary health professionals was however not as effective. Practitioner conversations highlighted communication between health and the placing Local Authority could have been improved. Cross boundary NHS professionals were not always made aware of relevant information by the local authority and health organisations from the placing authority. Looked after children (LAC) reviews did not include health data or participation by either the General Practitioner or the health professionals (School Nurses or CAMHS [4]

[3] See glossary for definition of reductionist theories.
[4] CAMHS is abbreviation for Child and Adolescent Mental Health Services, see glossary.

services). In line with guidance, the child makes the decision which professional attends the reviews and to ensure multi-agency involvement separate professional planning meetings are convened. However, health professionals (LA5) were not consistently invited to these planning meetings. This was a missed opportunity to share relevant historic and current information in a multi-professional forum.

Learning Point 4: The LSCB should be assured that professionals with responsibility for the health of LAC are invited to participate in multi-agency care planning meetings and that a summary of the child's history is provided when new professionals join either review process.

24. Attempts were made by the cross-boundary NHS community services, to secure historical health information. However, there was delay in receiving the information from the NHS (LA2). This resulted in an initial health review being undertaken without the benefit of historical health, social or educational information. There are challenges nationally in transferring health of looked after children information across NHS and Local Authority boundaries with no common transfer process. At the time the receiving NHS area (LA5) had clear transfer of care procedures which were not replicated in the local NHS arrangements (LA2). This system has now been strengthened in the local arrangements (LA2)

Learning Point 5: The LSCB should be assured that the NHS (LA2) has effective arrangements for transferring the health of LAC information across NHS boundaries. This could be evidenced through audit processes.

25. Information sharing is complex within child safeguarding and protection work. Cross boundary working increases this complexity. The electronic invite systems in Children's Social Care (LA2) do not automatically invite health professionals and other professionals from cross boundary health agencies. Children's Social Care have made recommendations to strengthen this area of practice. Communication is however a two-way process and all agencies have the responsibility to link in with the lead agency formally requesting participation in multi-agency arrangements.

26. ***Child Q: A Perspective of Child Protection, Statutory Intervention and Care Proceedings***. In December 2006, Child Q (aged 4 years) and the sibling group, became subject to child protection plans (category neglect). They were de-registered in March 2008, following improvements in the levels of care. The care was not sustained and 5 months later Child Q was accommodated by the Local Authority (LA2), using the powers under Section 20 of the Children Act 1989. Care proceedings were instigated late in 2008, when an application for a care order was made and final orders were made a month later, endorsing a plan for rehabilitation with the birth parents. In mid-2009 the Local Authority (LA2) filed a plan with the courts to terminate the plans for rehabilitation home, due to ongoing concerns regarding parental commitment and maternal drug misuse. This was not endorsed by the court and Child Q with 4 members of the sibling group returned home in September 2009.

27. Practitioners worked in partnership and with court directives when planning, assessing and making decisions about the care plan. The decision to return the children home was and remains concerning for practitioners. Child Q continued to experience neglectful parenting. Practitioners during the process of the review, expressed an overwhelming opinion that this contributed to the deterioration in Child Q's life experience, demonstrated by increasingly challenging behaviours and an increased risk of harm due to being left to wander the streets. This review has not had access to the court papers so does not criticise the decision, understanding the court's decision making is based on the evidential bundle presented to court.

However, practitioners advise this decision was a significant contributory factor in the failure to achieve permanency and stability for the child.

28. In November 2009, supervision orders were granted in respect of the children. However, in August 2010, 11 months after returning home the Local Authority (LA2) re-issued care proceedings in respect of Child Q and the sibling group. The care plan being to remove the children from the family home and place them back in foster care. Child Q had asked at this point to be removed back into the care system. In February 2012, Child Q became subject to a full care order. The transition into Local Authority accommodation was a challenge, the child went on to exhibit challenging and difficult behaviours including repeated episodes of missing from care, aggression, violence and episodes of self-harming.

29. The case relating to Child Q coincided with the LSCB's launch of a neglect strategy.[5] The key objectives contained within the strategy are in the process of implementation. The LSCB should maintain a focus on this strategy to ensure it impacts sufficiently on front line practice to improve the outcomes for children living with long term neglect.

Learning Point 6: The LSCB should be assured that the focus on the implementation of the neglect strategy is maintained to influence front line practice and improve the short and long-term outcomes for children living with the experience of neglect.

30. In conclusion despite the long term statutory interventions and care proceedings, Child Q's experience of abuse and neglect continued throughout childhood. Child Q's experience of daily living was most likely reflected in the presenting difficult and challenging behaviours. These behaviours escalated and possibly became a survival technique to manage the child's everyday living experience in the absence of good enough parenting. This experience is not new learning and is reflected in many reviews when children have lived with and had to survive the effects of long term neglect.

31. ***Child Q: Which System/Process Should Apply in Cases when CSE is a Factor?***
Child Q's case was managed under the statutory framework for children looked after. The evidence demonstrates that practice at the time, was in line with the requirements of guidance. The Independent Reviewing Officer offered scrutiny and practitioners reported the officer was extremely knowledgeable, provided positive leadership and constructive challenge. In December 2014, when CSE concerns escalated the case continued to be managed under the same statutory framework. Separate strategy meetings were convened (LA5) to manage the issues regarding CSE.

Good Practice Point 3: The Independent Reviewing Officer offered scrutiny, expertise, case knowledge, positive leadership and constructive challenge. This was commended by multi-agency partners.

32. During conversations, practitioners were asked which system would be used to support the management CSE cases. It was confirmed that cases involving LAC would most likely be managed through the LAC system. However, there was a lack of clarity of other cases that did not fall under the umbrella of the LAC system. Some practitioners thought these children might be monitored through a Child protection plan and others believed the Specialist Child

[5] LSCB: Neglect Strategy and Action Plan 2015-17.

Exploitation Team would manage the case. The child protection system could help to provide consistency in the planning process for all children at risk of CSE. However currently there are concerns nationally that this system does not have a specific category for this type of abuse. Crime reporting also cannot support the coordination of cases as currently CSE is not a separate category and the data is offender based. This confusion is being replicated nationally [6] [7] and national guidance is awaited. Safeguarding pathways for the management of CSE should be clarified locally. This will strengthen front line practice and ensure consistency in the management of cases when CSE is a feature. The findings of national research should also be reviewed to inform the development of the pathways.

Learning Point 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.

33. The review process was unable to ascertain with confidence that all known intelligence and data regarding CSE activity was collated across statutory, third sector, voluntary sector, partner agencies and cross boundary organisations under one umbrella. This creates challenges for the LSCB in problem profiling for their child population. Assessing and identifying local patterns of CSE, which then informs local practice developments and strategic decision making is crucial for the future development of provision.

34. In January 2015, a local specialist CSE team (LA2) was commissioned. However, the service will not necessarily have access to data regarding local children who are exploited in cross boundary areas. The collation of data in respect of CSE is complex. Data collation systems are unclear and should be strengthened to ensure the scope of the problem for the local child population is fully understood by strategic partners.

35. The arrangements for multi-agency strategic scrutiny of local CSE data needs to evolve in line with emerging and evolving local and national findings/evidence. This is crucial if effective local services are to be commissioned and developed to accurately reflect the needs of this specific client group.

36. ***Child Q: The Challenges in Securing Permanency.***
Achieving permanency in residential foster care accommodation was unsuccessful. At least 12 foster placements and a 11-month period of living at home were documented between August 2008 and August 2012. This was despite the positive efforts of the Social Worker and Local Authority placement team to secure permanency. Placement with members of the sibling group was also unsuccessful. The reasons were multi-factorial and included; relationship breakdown between foster carers, foster carers giving notice to cease the placement due to being unable to manage the child's challenging behaviour and aggression directed to other children in the residential accommodation.

37. In August 2012 (10 years 4 months), a placement was secured for Child Q in a Local Authority residential care home (LA2). Child Q however after an initial period of stability child became extremely unsettled, with an increase in missing episodes and escalating incidents of

[6] NSPCC on line, downloaded 28.6.16.
[7] Berelowitz et al (2012) "I thought was the only one. The only one in the world" The office of the children's commissioner. London.

aggressive behaviour to other children and staff. Restrictive practices were used including notable levels of physical restraint. This use of physical restraint will be discussed further in this report. It is positive that four high level multi-agency strategic planning meetings were convened in late 2012 and early 2013 to provide leadership. Independent psychological expertise was commissioned to; undertake work with the child, provide coordination within the care pathway and provide expert consultation to multi-agency professionals.

Good Practice Point 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.

38. During the strategic planning meetings, the Constabulary expressed significant concern for the child's welfare, believing a secure unit placement would be the preferred option to manage the risk. A consensus opinion was reached after constructive debate. A new specialist residential placement in a Specialist Children's Home would be identified and commissioned. However, there was significant debate as to whether this should be a sole or a multi-occupancy placement. The current placement was struggling to manage Child Q's complex presentation, felt unable to keep the child safe and staff were traumatised by the levels of aggression levied against them and the other children. Although at the time, there was agreement to increase the staffing establishment, it was proving difficult to maintain the required staffing levels. The child had also expressed it would be preferable to live on the streets, had hidden belongings in a bag and expressed a wish to move. The staff caring for the child were distressed by the child's presentation. Front line staff remained motivated to manage the challenges and focussed on trying to provide Child Q with a caring, nurturing environment irrespective of the challenges in achieving this. They were well supported by line management in trying to overcome the presenting challenges and managing the staff group's anxiety. At this point, there was no evidence the child was or had been a victim of CSE, although was clearly at risk due to complex vulnerabilities. Practitioners advised they worked consistently with Child Q through keep safe work, to try to prevent the child from being exploited.

Good Practice Point 5: The residential care staff (LA2) 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.

39. In 2013, prior to the transition, improvements in Child Q's behaviour were highlighted and the child became generally more settled. Two main theories emerged for this improvement; the behaviour management support had begun to have a positive effect and the child was aware a move would be imminent (although had not at that point been told). It has not been possible during the review to identify whether the senior leaders were aware of the improvements. During practitioner conversations, several factors were identified as potential reasons for the continued placement plan. Child Q was requesting the move, staff were traumatised/anxious when providing care, there were challenges in maintaining the increased level of staffing and locally there was no Secondary School suitable for Child Q. Financial considerations were discussed as a possible factor. The Local Authority Children's Home would normally accommodate three children and was not funded to be a sole occupancy unit, as was required. At the time of planning the change in placement, the Expert Psychologist and Systemic Psychotherapist expressed concerns about the proposed placement move, advising that the break in stability

and continuity could cause further de-stabilisation. Other professionals had also expressed concerns about the move into a multi-occupancy unit.

Learning Point 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.

40. In May 2013, an Independent Specialist Children's Residential Home placement with separate education facilities was secured in a cross boundary area (LA5). A transition plan was established. Placement in the residential home was complete in May 2013 and in the educational facility by September 2013 in preparation for starting Secondary School education. The establishment was a multi-occupancy establishment and initially Child Q exhibited challenging behaviours towards the other children. Behaviour strategies were quickly established and practitioners reported that Child Q settled quickly with a gradual reduction in aggressive outbursts and missing episodes. The placement was maintained until the trigger event in February 2015 when Child Q (aged 12 years), was placed in a secure unit pending the identification of a suitable placement. Child Q expressed a wish not to return to the independent accommodation following the trigger event.

41. The transition to the independent specialist residential home was well managed and the child was fully involved in the planning and preparation arrangements. The key Social Worker was commended by multi-agency colleagues in respect to how the case was managed across boundaries. Whilst the placement was perceived as a specialist placement, the Residential Children's Home provision (LA5) was very like the provision in LA2, but with additional specialist support in respect of specialist education and psychological services.

Good Practice Point 6: The key Social Worker was commended by multi-agency practitioners in the coordination of multi-agency cooperation across the boundaries.

42. In conclusion, Child Q's experience of placements is not unusual for children who are looked after and there are multi-factorial reasons as to why permanency was not achieved. National and local work is underway to strengthen these systems. During conversations, Residential Care Workers across the areas clearly aspired to provide a caring, nurturing home environment for Child Q. Their motivation to make the placement work in the child's best interest was evident. The leadership oversight was a positive initiative and supportive to frontline delivery. Commissioning an Independent Expert Psychologist was positive but interestingly the expert opinion offered did not impact on the placement decision to move Child Q. A strategic plan was formulated to place the child into a more specialist placement however it has not been possible to ascertain how the plan was reviewed in line with Child Q's improving presentation. The plans to move Child Q were possibly developed too quickly, before the child had a reasonable time to settle into the local placement. Once the planning had begun it seems the organisational cogs just kept turning until a specialist residential placement was identified, irrespective of the improvements. This case identifies the child should be given sufficient time to settle before preparing for another move. If the child's presentation begins to stabilise, the placement plans should always be re-considered. The decision-making process regarding placement moves should be based solely on the what is in the child's best interest at the time.

Good Practice Point 7: The Residential Care Workers across the areas were focused on Child Q's needs and continually aspired to provide a caring, nurturing home environment to meet the child's complex needs.

Learning Point 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.

43. A significant question is, should a Primary School child, who has a significant history of missing episodes from care, having been subject to long standing neglect, with attachment difficulties ever be placed in a Residential Children's Home. This is currently subject to national debate and there are mixed perspectives. This was not the preferred option for Child Q, but given the numerous failed foster placements strategic leaders reached a consensus that placement in a specialist residential care home with educational facilities was perhaps one of the remaining options available. The preferred option could have been that Child Q was placed with specialist foster carers who could support a child at high risk of CSE, in a nurturing home environment however such placements were difficult to identify at the time. Nationally such models of care are described [8] which demonstrate improved outcomes for children. Unfortunately, this option was not available for Child Q who at the time, seemed to respond better to sole placements with one to one care.

Learning Point 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 can build a safe and trusting relationship with the child. Commissioning arrangements should be strengthened to secure the availability of such places.

44. ***Child Q: A Psychological Profile*****.**
In late 2009, within 1 month of Child Q returning home, the eldest sibling died unexpectedly, by his/her own hand, having expressed suicidal ideation. Consistently practitioners identified this bereavement had a profound impact on Child Q, although this perspective cannot be absolutely quantified within the content of this review as the sole explanation of the child's behaviour. Child Q's behaviour became more challenging around the anniversary of the bereavement. Professionals (LA5), recognised the need to support the child's emotional/psychological well-being around the anniversary of the bereavement and planned special activities to support the child through this difficult time.

Good Practice Point 8: The impact of bereavement on Child Q was acknowledged by Residential Care Workers (area 5) who anticipated the potential impact on Child Q's emotional presentation and planned special activities with the child to acknowledge the event.

45. In 2011, during proceedings an expert psychological report presented Child Q as the most vulnerable and emotionally fragile of the sibling group. This was due to behavioural outbursts and a lack of ability to self-regulate. It highlighted the child was likely to need significant additional resources over the future years. Child Q was statemented for special educational needs (social, emotional and behavioural) and was placed in a new special needs Primary School provision (LA 2) prior to attending Secondary Education. This was a positive placement

[8] Shuker L (2013) Evaluation of Barnardos Safe Accommodation Project for Sexually Exploited and Trafficked Young People. University of Bedfordshire.

for Child Q and positive relationships with Teachers were noted, demonstrating the child's capacity to respond positively if the conditions were right to facilitate the response. Child Q demonstrated a positive relationship with a learning mentor in the Primary School which was commended by other professionals in enabling the child to feel secure in school. The Primary School did an "excellent job" in containing the child and understood the child well. When Child Q was having a good day, the school gave the child additional responsibilities, including working with other children and supporting them in their activities.

Good Practice Point 9: The Primary School could provide an environment that enabled Child Q to form positive and constructive relationships with the adults providing the service.

46. Child Q's access to psychological/mental health services was complex. At times, three professionals were involved in the provision of emotional support/psychological services to Child Q. In December 2012, it was innovative and positive that the Local Authority (LA2) commissioned the expertise of an Independent Consultant Clinical Psychologist and Systemic Psychotherapist. [9] The commission was to; provide expert support to professionals, offer support to reduce the missing/absconding episodes and coordinate the emotional /psychological care across the Local Authority areas and individual work with the child. This action was supported by the CAMHS (LA2) who had previously provided some assessment and intervention work but were unable to provide the intervention required at the time.

47. In 2013, the commissioned expert advised Child Q was sceptical and ambivalent about engaging in psychological therapies with adults, having tried them before. Multiple placements and changes in adult caregivers had not helped the child's engagement with parental authority figures. The child's experience of abuse and neglect by adult caregivers compounded the child's response to the adults trying to undertake therapy. The reasons for engagement or non-engagement were multi-factorial.

48. This commission was perceived as positive during practitioner conversations (LA2). The benefits this expertise had on practice when working with Child Q and other children was highlighted. In September 2013 when Child Q had moved into the cross boundary (LA5) Residential Children's Home, this provision became less well used and its purpose less well understood. Care Workers explained the Independent Group[10] (LA5) had their own specialist psychological services. The Independent Consultant Clinical Psychologist and Systemic Psychotherapist closed Child Q's case in December 2013. However, in September 2014 and January 2015, Child Q was referred to a different CAMHS [11] by the General Practitioner, after discussion with the Residential Care Worker. The case was referred as a new case rather than a transferred case which created some challenges and delay in the access to the service.

Good Practice Point 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.

[9] Role and function of a Clinical Psychologist and Systemic Psychotherapist described in glossary.
[10] The Independent Group in LA5 was commissioned to provide both specialist education and care provision including specialist psychological support.
[11] See definition CAMHS in Glossary.

49. It has not been ascertained whether this occurred in consultation with the lead Clinical Psychologist employed by the Independent Group. This raises the question that if services are commissioned independently for children to reflect the needs for psychological and mental health provision at what point should new NHS specialist Child and Adolescent Mental Health Services become involved. The thresholds for duplicate mental health provisions need to be clarified to reduce the risk of duplication of effort and the impacts of repeated start again[12] assessments on the child.

Learning Point 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.

50. In conclusion, trauma based interventions are crucial for children who are survivors of child abuse. The same principles should be applied for children as victims of CSE. At times, the focus of attention for professionals was the management of the child's behaviours without a true understanding that the presenting behaviours were a legitimate response to the abuse. It is positive that psychological expertise, coordination and therapy to enable staff to feel more confident in managing the behaviours was provided but also concerning that the expert opinion was not heeded in the placement planning. Psychological therapy is normally most effective in periods of stability where adult caregivers are consistent and the placements are stable. This should be good practice and be enabled to develop. Commissioners should evaluate the effectiveness of psychological interventions commissioned for this group of children. However, given the instability in placements and main caregivers supporting Child Q it is not surprising that the child's response to planned interventions was not always as effective as they could have been.

Learning Point 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.

51. ***Child Q: Behaviour Management Strategies.***
In 2012, at the age of 10 years, Child Q was arrested by the Constabulary (area 2) for breach of the peace, on five occasions over a five-week period. One of the arrests refers to the use of physical restraint in the presence of several officers. Criminal proceedings were not progressed. The Constabulary (Police Force 1) has recently reviewed its approach in line with national guidance in respect of the arrest and criminalisation of young children.

52. Between August 2012 and February 2015, restrictive practices were used, frequently, to manage Child Q's aggressive and violent outbursts. In this period, Child Q was placed in two children's homes (LA2 and LA5). Differing restrictive practices (PRICE[13] and Team Teach[14]) were used in residential care and educational establishments across the Local Authority areas. Both methods are documented as acceptable methods of restraint, however there is some

[12] Brandon et al (2009) Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-07 DCSF London.
[13] See definition of PRICE restraint in glossary.
[14] See definition of Team Teach restraint in glossary.

debate whether the PRICE technique (LA2) should be used on children younger than 13 years. Child Q was 11 years old when subjected to this technique.

53. The description of Child Q's behaviours makes disturbing reading and is clearly indicative of a very troubled young person. It is not difficult to comprehend the negative impact of the use of restraint may have had on Child Q. It may have led to the reinforcement of adult power to control, an experience well known to Child Q, mirroring the child's experience during abuse. It is also understandable that staff were required to protect others and themselves from harm and only used restraint methods as a last resort. Residential professionals (LA2) were shocked at the levels of restraint required to manage such a young child, traumatised, regularly assaulted necessitating hospital attendance and felt very much out of their depth of capability whilst trying to care for Child Q. However, their motivation to remain focussed on providing Child Q with a nurturing, supportive environment was evident. The organisations had relevant policies and procedures and described training opportunities to ensure the techniques used were expected practice. Supervision was also available to support staff on both a planned and ad hoc basis.

Learning Point 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.

54. Early in 2013, Child Q attended a local hospital accident and emergency department with a foot injury. During this visit, physical restraint was used following an assault on the carers and hospital staff. This will be discussed later in the review. It is notable that some of these events were around the anniversary of a significant bereavement. During conversations, it was identified that the two methods of restrictive practice are used across LA2. The "*Team Teach*" technique is used in education whereas the "*PRICE"* technique is used in the Residential Children's Homes. Child Q therefore may have had to accommodate and respond to both types of restrictive practice creating more confusion for the child.

55. In the cross boundary, Independent Children's Home with separate education facilities (LA5) "*Team Teach*" is used as the restrictive practice approach. Practitioner conversations highlighted that Child Q responded to this approach and the episodes requiring the use of restraint reduced significantly.

56. During practitioner conversations, it was evident that monitoring of physical restraint episodes was undertaken in both LA5 and LA2. Monitoring and scrutiny of the data in respect of restraint varied considerably. The local monitoring arrangements (LA2) were more dependent on individual analysis rather than a systemic analysis of the data. Conversations highlighted that scrutiny of the issue would normally be through the line manager, Ofsted or the child's Social Worker. The cross-boundary organisation (LA 5) provided details of the monitoring arrangements through an organisational system which included analysis of events and across the service. The scrutiny of the practice was independent via Ofsted, the Team Teach organisation and through the organisation's executive governance committee.

Good Practice Point 11: The organisational assurance system for the management of restrictive practices when working with children in Residential Children's Homes (LA5) was well organised with clear organisational reporting systems and independent scrutiny.

57. There are significant challenges in providing a safe nurturing environment for children with challenging and violent behaviour, who may also be at risk of CSE. The use of restrictive

practices when working with children is well documented nationally and has been subject to considerable debate. There is flexibility for services in the approach used. During the review process, there was no evidence presented to demonstrate that restrictive practices were used inappropriately or that guidance and policies used at the time were not adhered to. Professionals discussed that physical restraint would always be used as a last resort to protect other children or staff.

58. The use of restrictive practices and physical restraint should have robust monitoring and assurance systems to ensure children are safe. Local arrangements (LA2) should be evaluated and strengthened to ensure the process is safe when working to support children with challenging behaviour. From a child centred perspective, it's not difficult to conceive how the use of high levels of physical restraint could have made Child Q feel and may have reinforced the child and adult power imbalance mirrored in the child's experience of child abuse and neglect. The use of frequent restraint would conceivably have increased the child's response to fight the system that was providing care, heightened the child's defence mechanisms and led the child to present sometimes challenging behaviours as a survival technique.

Learning Point 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.

59. ***Child Q: Legal Issues and Offender Disruption Activity*****.**
In February 2015, child abduction notices[15] were signed by the cross boundary Local Authority (area 5) against a 23-year-old male to protect Child Q. There was evidence that the male was allowing the child access to drugs and alcohol in the property and gave rise to concerns regarding CSE. The Constabulary (Police Force 4) was unable to locate the male and could not serve the notice for a further 15 days.

60. In the same period, Child Q was also subject to a sexual assault by a different older male, aged 45 years. In February 2015, criminal proceedings were invoked against the older male for sexual offences against Child Q. The evidence for the prosecution case was gathered by the cross-boundary Constabulary (Police Force 4). The Constabulary advised there was no evidence to link the activity of the offenders.

61. In April 2015, the criminal trial of the 45-year-old male, secured a guilty verdict. The charges related to breaching a previous sexual offence prevention order (SOPO) and inciting sexual activity and grooming. The offender received two seven year sentences, to run concurrently. The offender had previous sexual offence convictions against children, that pre-dated the abuse perpetrated on Child Q by 10 years. The offender was subject to monitoring by the Constabulary (Police Force 1) at the time of the offence against Child Q. The Detective Inspector of the Sex Offenders Management Team (Police Force 1) completed a comprehensive review covering a 10-year period of working with the offender, as part of this review process. The review focused on the offender's management history; including the SOPO details and the monitoring arrangements. The findings were that monitoring arrangements were mostly carried out in line with expected practice at the time and there was no intelligence to indicate the offender was

[15] See Child Abduction Notices in glossary.

actively grooming children on the internet. The review identified a gap in practice that occurred in 2007 which has now been addressed through policy, process and cultural change within the service. The management of sex offenders in the area 2 has now been centralised which has led to improved consistency in the management of sex offenders and enhanced supervision and management support for frontline professionals.

Good Practice Point 12: The Constabulary (Police Force 1) could 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.

62. At the time of the event the Social Worker advised that Child Q did not realise the abusive nature of the event, which is a common finding in such cases when children have been subject to CSE.[16] Child Q's perspective at the time was therefore understandable.

63. In 2016 following a late disclosure from Child Q, a second criminal trial was convened against the 45-year-old offender. Child Q's perspective had shifted understandably, now believing that a rape offence and CSE had occurred. The outcome of the criminal trial was a not guilty verdict to the offence of rape. The Constabulary's Police Support Officer at the time of writing this review continues to support the child, who was distressed at the result of the verdict and remains traumatised by the incident.

64. In May 2015, a successful prosecution was secured by the cross-boundary Constabulary (area 5) against a third offender. The offender was sentenced to a 12-month rehabilitation order, will be on the sex offenders register for life and is subject to a five-year sexual harm prevention order, having admitted offences of inciting a child to engage in sexual activity, possession of indecent images and attempting to groom Child Q. The offender reported that he thought the child was 15 years old. The offender did not meet Child Q and the offences were committed on line.

65. Offender disruption is a key component when managing CSE. This review demonstrates that the cross-boundary Constabulary (Police Force 4) was active and worked in partnership with the local Constabulary (area 2) to disrupt activity and secure convictions through a range of activities.

Good Practice Point 13: The Constabulary (Police Force 4) were effective in offender disruption and secured a range of convictions in respect of offences related to CSE**.**

66. ***Child Q: An Evaluation of Missing from Home/Care Episodes.***
Child Q began to go missing from home, school or care in 2010 (aged 8 years). This pattern of behaviour continued and escalated significantly towards the end of 2012, following an initial period of stability in the accommodation (LA2). There is documentary evidence in relation to 39 missing from care/home/education episodes that were reported to the Constabulary (Police Force 1) between April 2010 and August 2013. Practitioner conversations highlighted the child's missing episodes were at one point the highest regionally and that the police helicopter was dispatched on occasions to support the search. Between September 2013 and February 2015 when Child Q was accommodated in a cross boundary residential care establishment (LA 5) there appeared to be a reduction in missing episodes, with seven reported episodes. The

[16] Research in Practice (2015) Working effectively to address Child Exploitation: A Briefing.www.rip.org.uk

reported missing from care data does not include the numerous un-reported missing episodes when the child returned unprompted or carers searched and found Child Q. The multi-agency response across authority areas to the reported missing episodes was very effective in recovering the child.

Good Practice Point 14: The Constabulary across the areas prioritised and were effective in recovering Child Q during reported missing from care episodes.

67. The Residential Children's Homes appeared to have processes in place to manage missing from care episodes. Discussions with practitioners demonstrated that line management support was always available at the time of a missing event, across the areas. A significant issue highlighted by both Residential Children's Homes was the challenges in preventing Child Q from going missing from care. Practitioners highlighted the challenges of keeping Child Q contained when the risk of going missing was high. Residential Care Workers expressed a desire to prevent Child Q from leaving the home, however the responsible Local Authority advised that Child Q could not be detained against the child's will. Residential Care Workers felt powerless in their ability to keep Child Q safe. They were frustrated that as corporate parents they were unable to restrict the child's freedom, despite the child's young age. If the child decided to leave the accommodation irrespective of the time of day or night, they had to balance restricting the child's liberty and keeping Child Q safe. Workers would make significant attempts to follow Child Q or keep in contact via telephone. In the cross boundary, residential home, practitioners faced the same challenges however the emergence of new guidance was reported as useful in clarifying the issue. It would appear however that this guidance has been withdrawn when considering developing and emerging case law.[17] [18] There is currently uncertainty in law when a child is to be deprived of their liberty, in the manner that Child Q was, therefore the guidance is that authorisation should be sought through the High Court.

Learning Point 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.

68. The links between missing from care episodes and the risks of CSE are well known. Practitioners highlighted this as a significant issue for ongoing development. The evidence demonstrates that professionals followed the multi-agency working protocols available at the time in respect of reporting the events. Professionals also made considerable attempts to locate the child. They would search for Child Q and attempt to maintain contact with the child throughout the missing episodes. There were many events when Child Q returned unprompted and other times when the child contacted the carers to get a lift back to the home. The Constabulary across both areas provided leadership, expertise and made significant attempts to recover Child Q when an event was reported. Both areas had specialist missing from home coordinators and professionals understood coordinators' roles and function. Professionals highlighted significant positive developments in the service since the trigger event in 2015.

69. The missing events were regularly discussed within Child Q's LAC reviews, although the Children's Social Care learning summary indicates that the missing from care strategy meetings

[17] Ofsted (2014) Deprivation of Liberty- guidance for providers of children's homes and residential special schools. (withdrawn 2nd April 2015).
[18] Case law relating to AB (A Child: Deprivation of Liberty) [2015] EWHC (Fam)

should have been compliant with guidance and has made recommendations to strengthen this especially in relation to multi-agency involvement. The expected process was followed when Child Q returned and interviews were conducted with Child Q at an appropriate time.

70. The incident reports compiled by the Constabulary in both areas were made available to the review team. The reports provided a clear understanding of the episodes and were reported to be accessible during missing from care strategy meetings. The cross-boundary Constabulary advised that their system enabled them to access data to track children across Local Authority areas however locally the Constabulary were only able to access local data. This should be a consideration for future developments as CSE is a national issue as children are moved across the country. It is therefore conceivable that locally services are not always aware of all local children who are at high risk of CSE.

Learning Point 16: The LSCB should be assured that the local Constabulary (Police Force 1) investigates 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.

71. In conclusion, the understanding and management of children who go missing is constantly evolving and the systems will need to respond to new research and evidence. The review demonstrates the systems to support Child Q's missing from care episodes including leadership were effectively managed locally and in cross boundary areas.

72. ***Child Q: CSE and Managing the Risk.***
The placing authority (LA2) established a specialist CSE team around October 2015 therefore this provision was not available when Child Q was resident in the area. Despite this, practitioners were aware of the risks Child Q faced in respect of CSE and would seek advice and support through the missing from home specialist service (Police Force 1). The cross-boundary Constabulary (Police Force 4) had an established, experienced multi-agency specialist CSE service. The service had four operations, based in differing localities and had been recently subject to re-design. The locality operation (Police Force 4) was actively involved in managing the risk, supporting the interventions, providing support to multi-agency partners and offender disruption activities. Keep Safe preventative work was undertaken by multi-agency partners with Child Q between September 2012 and February 2015, on a regular basis in all local and cross boundary areas.

73. In December 2014, two months before the trigger event, the Emergency Duty Team (LA2) received information from a family member who expressed concerns that Child Q was interacting with three older males on social media sites. Child Q was referred to the Constabulary's specialist CSE operation (Police Force 4) by Children's Social Care (LA2) the following day. Following a series of strategy discussions with Children's Social Care and the care establishment, an initial multi-agency strategy meeting was convened one week later. A CSE risk assessment was completed and the case was risk assessed as amber. However, following discussion and ongoing expressions of concern by the residential children's home workers the Constabulary advised that their professional discretion enabled them to continue to view the case as very high risk. This was positive practice demonstrating effective analysis and critical thinking rather than just being reliant on a potential tick box to assess the risk.

Good Practice Point 15: The Constabulary (Police Force 4) 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.

74. The Constabulary's learning summary (Police Force 4) documented they advised the care establishment that Child Q would need to be supervised always. However, the residential home care workers had recollection of this request. This included visits and outings and reiterated the child should have no free time until the risk was de-escalated. Over the next 3 weeks two further strategy meetings were convened. The risk was never de-escalated and the expectation remained that the child would never be left unsupervised on outings. The challenges for residential workers in balancing the restrictions to the child's liberty which could have been described as a deprivation and managing the risks of harm were challenging.

75. This was the first case with features of CSE known to the Independent Residential Children's Home (LA5). Conversations with the Residential Care Workers commended the expertise and support offered by the Constabulary (Police Force 4) and the child's Social Worker (LA2). The Care Workers understood the CSE risks at the time, especially in view of the child's missing episode the previous weekend. The decision to leave Child Q unsupervised was made considering the child's improved behaviour at the time of the outing. The Constabulary (Police Force 4) advised the child should be under constant supervision until the risk was assessed to have reduced. There were legal challenges for the Care Workers in restricting the child's movements, which were not fully understood by the Constabulary or made clear within the multi-agency risk management plan.

Learning Point 17: The management of risk in cases with features of CSE is led by the specialist CSE multi-agency 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.

76. At the time the Children's Home had capacity to increase staffing ratios to support the increased supervision of Child Q and used this resource accordingly. The placement was not funded as a sole placement so inevitably there would have been challenges in supervising Child Q, as if in a sole placement, in the longer term. The Care Worker did not have the authority to restrict Child Q's liberty and could not "*lock the child in"* until the risk had de-escalated. The management of risk in such cases is complex and therefore will need to be strengthened to ensure multi-agency partners can manage the risk to children within their sphere of responsibility. Children who are victims of or at risk of CSE should always be given protection but also require the opportunity for independence. It's a complex issue to ensure the right balance is achieved and multi-agency understanding of each agencies position is crucial if the management of risk is to be effective.

Learning Point 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.

77. There were challenges for the Constabulary accessing Child Q's social media activity. The child provided details of the account and gave permission for the Constabulary to access the account. However, the child then created a new account that the Constabulary were unaware

of. Regular physical searches of the accommodation by the Constabulary and care staff were unable to find an additional hidden mobile device. Practitioner conversations highlighted that the search procedure is complex and difficult. The Constabulary and other professionals (prison officers) undertake specialist training to complete searches yet Care Workers are expected to undertake the task without specialist training. A key question is can additional devices be identified without the physical search. There are computer software programmes that will undertake the search for unknown devices without a physical search of accommodation being undertaken. Practitioner conversations highlighted the challenges in practice when trying to keep up to date with internet activity and technology and identified this as an ongoing learning need.

Learning Point 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

78. Practitioners across the areas highlighted that their knowledge in respect of managing the risk of CSE at the time of the event was very basic. However, around that time organisations had begun to develop systems including learning opportunities, policies and procedures, supervision processes and leadership in respect of the agenda. This provision has continued to evolve and recent practitioner conversations clearly identified the progress that had been made in supporting the workforce to undertake this challenging work in line with national expectations. Practitioners clearly articulated their concerns and hypothesised that Child Q was at risk of CSE and this was a predominate concern in their thinking when planning risk management strategies. Early intervention was planned to reduce the risk that Child Q would become a victim of CSE. However, it would seem in practice there is limited evaluation of the quality and effectiveness of this intervention.

79. ***Child Q: A Health Perspective.***
There were no significant concerns documented in respect to Child Q's general health. Child Q did not have any long term medical conditions requiring ongoing medication or treatment. In 2013, over a seven-month period, Child Q had eight attendances in NHS urgent care departments for skeletal injuries frequently following aggressive outbursts and falls. Child Q was also physically restrained on at least one occasion whilst in hospital. Communication with Child Q at times must have been challenging for health staff, however, there was no evidence presented to demonstrate attempts to communicate with Child Q. There is no evidence that the impact of the regular physical restraint as previously discussed, was a consideration or known to the urgent care assessment. The focus on the child was limited to managing the behaviours. This may have resulted in Child Q moving into a defence mechanism, by fighting the systems that were trying to manage the child.

Learning Point 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?

80. In 2013, there was a delay in transferring the health records between areas. This was because the school nursing service held onto the records as Child Q still attended a local primary school and would not attend the cross boundary secondary school until September 2013. The initial statutory health assessments were undertaken in the new area without historical information

being available to the service in LA5. In LA2 the School Nursing Service advised "*they felt out of their depth when undertaking assessments on children with complex needs".*

Learning Point 21: The LSCB should be assured that the NHS (LA2) 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.

81. The learning reviews and practitioner conversations have identified that health professionals did not feel they were fully involved in the multi-agency meetings and arrangements to support Child Q especially when the child moved into a cross boundary area (LA5). The chronology identifies however that there were occasions when health professionals were invited but could not attend the multi-agency meetings organised by Children's Social Care. Practitioner conversations have highlighted the capacity issues for the School Nursing Service in fulfilling the requirements in respect to attendance at multi-agency safeguarding meetings. Whilst this is an expectation and described in guidance, in practice it is not always possible to achieve. The Children's Social Care learning review has made recommendations in respect of ensuring the contribution of multi-agency partners. NHS organisations however should review the capacity of the service to ensure health has the capacity to participate in the multi-agency arrangements.

Learning Point 22: The LSCB should be assured that the NHS (LA 2 and LA5) reviews the capacity of the relevant services to ensure the health contribution to multi-agency arrangements relating to children looked after.

82. This review had some challenges in securing medical data from General Practice (LA 5). The request for information was not made till late in the process by the named doctor (LA2), due to some confusion as to whether the request for relevant personal and sensitive medical information for undertaking a serious case review was valid. The General Practice (LA2) responded quickly to the request. Child Q was known to the General Practitioner services and had attended several times as is evidenced in the chronology. In December 2014, Child Q attended the General Practitioner with re-current urinary tract infections. Whilst this is only rarely a sign that a child has been subject to sexual abuse, if other risk factors are present, it is an important factor to consider when building understanding of the child's experience. This information was not shared with multi-agency professionals for the LAC health reviews. General Practice did not contribute to multi-agency information sharing in practice and was not invited to attend partnership meetings in respect of this case.

83. Nationally the safeguarding role of General Practitioners is under debate due to concerns that their role is currently very much on the periphery of safeguarding work.[19] Although multi-agency practitioners understood the value of the General Practitioner's role in safeguarding work their experience was that General Practitioners (LA2) are rarely involved in multi-agency partnership work. This is in contrast with the cross-boundary area (LA5) where the General Practice is more involved and provided information for the review on request. General Practitioners are possibly the only group of professionals who have long term involvement with a family, therefore they have a significant role to play. Their role should be strengthened. This case reflects some

[19] RCGP, NSPCC, UCL, University of Surrey (2014) The GP's Role in Responding to Child Maltreatment: Time for a Re Think, an overview of policy, practice and research. July.

national findings from serious case reviews in that communication and partnership arrangements with General Practice should be strengthened.[20]

Learning Point 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.

84. ***Child Q: An Education Perspective.***
During the timescale of the review Child Q attended two education establishments in LA2 and LA5. The Educational Professionals could not attend the multi-agency practitioner events and a learning point has previously been made in respect of this. A practitioner conversation was undertaken on site, at the Independent Secondary School establishment.

85. Throughout multi-agency practitioner's conversations, there was regular praise that the Primary School could contain Child Q positively and this resulted in an improvement in the child's presentation. The child had a personalised educational curriculum and was taught on a 1:1 basis frequently also engaging in activities that helped to contain the child's presentation i.e. creating objects like origami. The child was statemented for special educational needs (emotional) and had good support by a Learning Mentor with whom the child developed a constructive relationship. The school worked closely with the Residential Care Workers (LA2) and communications were undertaken daily when Child Q's behaviours escalated. It is positive the Residential Care Workers and Primary School Professionals worked closely to manage the care plan. It is notable that Child Q reached expected educational attainment levels when leaving Primary School, achieving Grade 4 in all the national standard attainment tests.

86. The transition to the Independent Secondary School establishment was well managed enabling the child to attend for preparatory visits. The child was described as having a great personality that "drew you in". The school developed a personalised curriculum, noting that afternoons were a real "*hotspot"* for a deterioration in the child's behaviour. The afternoons were then dedicated to vocational studies such as cooking. The child began to attend the nurture provision in the school and initially it was a "*rocky"* start resulting in the need for regular, high level physical interventions. The physical interventions used were per the organisation's policy on the use of physical intervention and were ground level holds (team teach approach). Between September 2013 and December 2013, there were 17 incidents of which 12 were holds on the ground. The child would self-harm by pulling furniture over or by using pencil sharpeners to the child's arms and legs. The child's challenging behaviours began to reduce and between Spring and Summer 2014, the child's behaviours were much more positive. It was described as "***a good period"***. There was twice daily feedback in the handover arrangements between the Independent Secondary School and the Children's Home, so communication was generally good.

Good Practice Point 16: The transition to Secondary School was well managed and daily the Residential Care establishments and Education establishments would ensure that relevant information was shared to ensure coordination and consistency in care planning.

[20] NSPCC repository, SCR Baby E, library.nspcc.org.uk, downloaded 23.11.15.

87. The Secondary School had to exclude Child Q, due to aggression against staff on a few occasions. Exclusions were managed, work was sent home and there were return to School meetings. The School held regular meetings with the team (teacher, pastoral support and therapists) supporting Child Q. A "*my support plan*" system was developed with the child. It was felt the child understood the risks and dangers of behaviours, both when happy and settled and when spontaneous and unsettled. The child "*loved"* the sessions with the psychological therapist who brought along a therapy dog. These sessions were not formally evaluated.

88. The child began to abscond regularly from school from September 2014 with some significant episodes (540 minutes). The child self-reported to be hiding around the school and saw staff searching. Most absences were short duration of less than 30 minutes and if absent for longer than 30 minutes the school would contact the Constabulary's Missing from Home Team (Police Force 4) who were advised to be very supportive (LA5). It was difficult to understand the triggers predicting a missing from school episode, as so many incidents were sudden and spontaneous. It was noted that again the child developed a positive relationship with an Educational Professional.

89. The school understood the child had a mobile telephone whilst in school. The school felt that their "*hands were tied*" as they couldn't access the child's social network accounts and check who the child was talking to on line. This was a significant frustration and incident reports were raised in the organisation in respect of this.

90. This was the school 's initial experience of a case with features of CSE. At the time of the event the professionals understood CSE but had only had limited learning opportunities. This event spearheaded a programme of learning via internal and external learning events, a review of policies, guidance, documentation and organisational monitoring, the introduction of monitoring and scrutiny of high risk cases via the organisation's safeguarding expert, improved links to the area's CSE specialist team and a programme of preventative work with other students.

91. In conclusion, the education establishments worked effectively to support Child Q. Communication with the child and collaboration with other multi-agency partners was at the heart of their intervention. The Secondary School has because of this incident used the learning to review their systems and improve their understanding of how to work with CSE However following recent case law [21] there are significant challenges and debate for agencies to resolve in accessing and monitoring the use of communication modes by children who are looked after, to avoid depriving the child of their liberty.

[21] Case law relating to AB (A Child: Deprivation of Liberty) [2015] EWHC (Fam)

2.3 Child Q: Conclusion.

Table 2: Analysis of Interacting risk factors (focussing on factors known at the time of the trigger event). [22]

Background Hazards known at the time	**Situational Hazards known at the time**
Increase in self harming activities. Increased frequency of MFC episodes. Streetwise yet emotionally immature Psychological profile impulsive, no fear of situations Extensive history of abuse and neglect Effects of separation and loss. History of disorganized attachments. Child able to see life in chapters which can be easily shut. Significant history of placement instability Positive relationships with peers sometime challenging. Knowledge regarding keeping safe and sexual health limited. Young child (aged 12).	Risk of restrictions being a deprivation of liberty. Missing from care overnight episode. Internet and social media activity **Situational hazards unknown** An unknown mobile device. Involved in a risky, exploitative behaviour with a known offender
Strengths/protective factors known at the time	**Dangers known at the time**
A stable placement (21 months) Regular attendance at school (18 months) Care workers with good insight into the child's needs. Clear expectations of behaviour Regular child centred communication Action packed diary of activities Consistent key social work support. Offender Disruption Activity Reduction in conflict with carers	Involvement of child communicating with older males via internet. Engaging in risk taking internet, social media site activity Association with risky adults.

93. The review has considered whether the events leading to Child Q becoming a victim of CSE could have been predicted or prevented. The multi-agency service provision of services across Local Authority boundaries has been critically appraised to identify that if information had been effectively and systematically compiled could a prediction of harm have been identified and the risk more effectively managed.

94. Critical reflection on this case identifies the multi-agency management of CSE is multi-faceted and therefore it cannot be an exact science to determine the root cause for the abuse occurring. The child is a victim of CSE because a persuasive adult or older person is intent on engaging the child in inappropriate sexual activity and other risk taking behaviours associated with CSE.

[22] Acknowledgement to Ball K (NSPCC) for the use of the Analysis of interrelating risk factors methodology, contained in SCR Child N, Lancashire 2015, SCR repository.

95. The motivation of all multi-agency professionals/workers, with no exceptions, was to protect Child Q from CSE and this was a central consideration in care planning. In general, multi-agency partnership work was good with evidence of strategic management oversight. At times workers involved in the daily care of Child Q had to make and balance the conflicts of different systems when trying to manage the risk of further missing episodes, yet make decisions to give Child Q some autonomy and the child's life some degree of normality.

96. 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 considering the child's wishes not to be different from the peer group. Research provides some clarity that even if children are known to be CSE victims they should be both afforded autonomy in everyday decisions about their life, but also be provided with protection. Creating the right balance for care worker's engagement with children is essential. An alternative hypothesis given Child Q's missing from care history, is that the child would have gone missing at another opportune time irrespective of whether the Care Workers were present or not. The Care Worker could not "*lock the child in*" in their role as corporate parents.

97. An overwhelming consideration is that children whose life experience has been about living and surviving the trauma of child neglect and abuse, have been linked, to an increased vulnerability to be exploited through CSE. Child Q's history provides significant insight of a long history of trauma, instability and separation and loss resulting in the development of defence mechanisms, challenging behaviours and survival. The child's past therefore must play a contributory factor in the circumstances that led to the child's experience of CSE.

98. The answer to the research question. "*How is the LSCB assured that we protect children at risk of CSE when placed outside the borough"* is clearly answered in this case in that; 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 child had the longest period of placement stability whilst in the cross-boundary children's home.

99. ***Predictability and Preventability.***
In conclusion when analysing the interacting risk factors (see table 2) the possibility of Child Q becoming a victim of CSE was potentially predictable but at the time not preventable. There was not a single event identified during the review process that could enabled professionals prevent Child Q from becoming a victim of CSE. The outcome for Child Q was possibly 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.

SECTION 3: CHILD S SERIOUS CASE REVIEW

3.1 Child S: A Synopsis.

101. ***A Portrait of Child S***.
Practitioners providing care for Child S always described the child as a pleasant and polite young person, who was always keen to maintain a good appearance. Child S was reported to have a very caring nature, evidenced by a strong desire to care for the child's own mother when she was struggling to cope. In practitioner conversations, it was highlighted that on some occasions, when truanting from school, Child S would sit on a hill and observe the mother's activities around the flat they lived in. Child S often presented as a sensible and mature child, who was extremely streetwise. Professionals recognised the challenging behaviours (frequent missing episodes, shoplifting, occasional aggression) exhibited by Child S were most likely a defence mechanism, because of enduring and long term neglect combined with inadequate care and poor parenting.

102. Educationally, there were significant challenges in securing the child's attendance rates. In Primary School Child S was well supported to attend and staff regularly went to find and bring the child to school when absent. The school would consistently provide for the child's basic needs. In November 2014, during the first term in Secondary School, Child S's attendance rate was only 66.7% and it was regularly noted that the child attended school very dishevelled and hungry. On at least one occasion the school provided the child with new shoes and a uniform. In September 2015, on entry to a new Secondary School, it was noted that Child S's academic attainments were not at the expected level. An individual timetable was provided to meet Child S's individual needs with 1:1 support in class. The option of a small focused support group out of class was also offered and learning mentor support was provided to encourage improvements in academic attainment.

103. ***A Summary of Child S's Life***.
Child S was an only child and lived in LA2 with the child's mother. Child S's birth parents separated in the child's early years and then Child S had minimal contact with the birth-father. The relationship with the birth-father has only recently been re-established. Child S's birth-father has two other children who are the child's half siblings and live out of LA2. 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 and Child S exhibited a close attachment to her. Child S also had close, extended family relationships and contacts with cousins. The child's attachment with the mother was assessed to be ambivalent [23] and disorganised [24].

104. In 2009, Child S was 6 years of age when the child and mother moved out of the family home. This coincided with several significant family events including; two significant family bereavements (grandfather and uncle), the maternal grandma went missing for approximately one year and Child S's mother also spent some time away in prison. Practitioners discussed that when the mother had sole care of Child S, the child's care deteriorated. Child S was seen shoplifting with the mother (aged 7years), caught shoplifting (aged 11 years for perfume, food) and the child regularly disclosed an insufficient food supply at home and a chaotic environment. Child S later disclosed to a foster carer, that regular shoplifting was the way the child got food and clothing, due to the absence of these necessities in the home. In Primary School, Child S's

[23] See glossary for meaning of ambivalent attachment.
[24] See glossary for meaning of disorganised attachment.

attendance was supported by professionals who would go and search for the child to encourage regular school attendance and then provide food to meet Child S's basic needs. Child S's attendance and presentation at Secondary School deteriorated without this intensive additional pastoral support. The deterioration was recognised early by the Secondary School. 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.

105. Child S was regularly reported missing from either 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. Partnership work with Child S's mother was often challenging and not productive due to issues of non-compliance. The mother had her own significant challenges (mental health, substance misuse, criminality) and these issues contributed to her presentation being unpredictable (irrational, angry or upset) making partnership work difficult. She was subject to criminal justice monitoring and rehabilitation arrangements following convictions but was generally non-compliant in these arrangements. The review has not been able to evidence that Child S's mother could provide good enough parenting for her child, whilst she had sole care. The perspective of practitioners was that whilst the grandmother supported childcare arrangements Child S received good enough parenting up to the age of 6 years. There were significant concerns that Child S's mother and other family members may have at times not disclosed Child S's whereabouts during missing episodes, and thus some family members were served with harbouring notices and direct contact with the family was suspended. A Recovery Order was granted due to reasonable concerns that family members were harbouring Child S. At other times the intelligence from the family and peers was instrumental in securing Child S's recovery when missing from care.

106. Between 2013 and 2015, Child S was subject to monitoring and intervention by multi-agency services due to escalating child concerns. This intervention was under the processes related to the common assessment framework (CAF),[25] child in need [26](CIN) and child protection. There were at least 11 contacts/referrals and numerous missing notifications in this period before the child became subject to somewhat unclear, CIN arrangements (Section 17 Children Act). The thresholds between CIN and early intervention through the CAF were at times confused. 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 by LA2 in a series of foster care placements and residential children's homes locally and in cross boundary areas.

107. In November 2014, when Child S was aged 11 years, a referral was made to the local, newly established, specialist CSE team (Police Force 1). However, the risk was assessed as low and the case closed following a referral to Barnardos for therapeutic work. Another referral was made to the specialist CSE team (Police Force 1) in May 2015, however the risk of CSE was again assessed as low with a referral to Barnardos to be considered. In July 2015, a further referral was made to Barnardos for support.

[25] See glossary for understanding re common assessment framework.
[26] See glossary for definition of child in need

108. ***Child S: The Trigger Event (aged 12 years).***
In December 2015, Child S was placed in an out of area placement (LA6) but went missing 2 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.

109. Child S is now placed near to home, in a cross boundary, Specialist Residential Children's Home with care and educational facilities. Child S requested this type of placement. Child S has been assessed psychologically and is responding well to the behaviour management strategies, developed because 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 maintained a level of contact with family members as part of the care plan. Child S has developed a positive relationship with the allocated LAC Social Worker who has been consistently allocated since Child S became looked after in May 2015.

3.2 Child S's Story- A Chronological Analysis.

110. This section provides a chronological analysis inclusive of the child's story and an analysis of significant events and themes. The original timeline set for review was between November 2013 and November 2015. However, further relevant events were identified after November 2015, hence the timeline for review was extended to January 2016. A perspective of relevant historic issues and themes is also offered within the review. Good practice and learning points are identified throughout the text. The Local Authority and its partner agencies are currently implementing an improvement plan following an Ofsted Inspection in 2014.[27] Therefore, most learning points contained within this review are already known to the LSCB and its partner agencies and are subject to implementation.

111. ***Child S: The Retrieval of Historic Information and Information Sharing.***
Child S resided in the responsible authority area (LA2) from birth. In 2010, historic information retrieved from Children's Social Care detailed child protection referrals from housing (maternal shoplifting offences and substance misuse issues). The shoplifting offence occurred in the presence of Child S, who was 7 years of age at the time of the offence.

112. In 2012, two further contacts/referrals were made to Children's Social Care by housing. These provided indicators of neglect; poor home conditions, poor attendance and the risk of losing their home. A single assessment was completed by Children's Social Care, with the outcome to proceed to an assessment under the CAF. No further information was made available to support understanding of how the CAF was instigated during 2013, how the outcomes for Child S were assessed, how the risk was managed or how multi-agency partners were involved in the

[27] Ofsted undertook an Inspection of services for children in need of help and protection, children looked after and care leavers and a review of the effectiveness of the LSCB.

planning or intervention processes. The use of the CAF in practice will be discussed later in the content of this report.

113. During 2013, Child S's mother received a suspended sentence for handling stolen goods and became subject to a programme for Building Skills for Recovery [28] and Supervision. The review has not been able to identify whether between 2010 and 2014 the Social Workers and their line managers accessed internal historic information from the child protection information system, to build a chronology to support the assessment of risk and neglect. Professionals reported that access to the CAF information was more challenging for Children's Social Care at that time, therefore building an accurate chronology must have been difficult. The information retrieval system has significantly evolved over the previous 2 years with the formation of the multi-agency safeguarding hub (MASH) and professional conversations highlighted that the coordination of the CAF has been strengthened within the local authority through the development of a new early help assessment service. Professional discussions highlighted that the MASH has changed the way historic information is collated and this process is now much more effective in assessing factors indicative of neglect. This is an action in the improvement plan.

114. The historic information provided significant evidence that should have alerted professionals to provide early multi-agency intervention programmes and proportionate interventions to manage the neglectful parenting and home environment. This was a missed opportunity to provide early intervention and improve Child S's daily life experience.

Learning Point 24: The LSCB should be assured that Children's Social Care information system can 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.

115. Practitioners identified the allocation of a key experienced Social Worker from the LAC Team in May 2015, had significantly improved multi-agency understanding of historical issues. Pre-dating May 2015, there was minimal evidence that historical information was used to influence care planning or manage the risk for Child S. The Children Looked After Social Worker had the insight to explore the child's early years, through discussions with family members. It was only known then that up to the age of 6 years, the child's life was stable, receiving good enough care from the mother and maternal grandma. Following two significant bereavements (grandfather and uncle) the child's grandmother went missing for one year. The child moved to live with the mother and following this the quality of care for Child S significantly deteriorated. The importance of the child and parent's history is crucial especially when working with chronic neglect to help work with the root cause of neglect and prevent repeated "start again" [29] [30] assessments.

[28] See Glossary for more understanding of programme for building skills for recovery.
[29] Brandon et al (2009) Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-07 DCSF London.
[30] See glossary for meaning of start again syndrome.

Good Practice Point 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.

116. During the review period, there was evidence of positive communications and information sharing especially between the Primary and Secondary Schools, the School Nursing Service and Family Support Services. However, professionals highlighted during the initial 12 months of the review period that information sharing could have been stronger between Children's Social Care and multi-agency partners. Communications highlighted this significantly improved in the latter half of the review period. The re-designed Early Help Services and the allocation of the Children Looked After Social Worker were highlighted to have significantly contributed to the improvements. Practitioners also highlighted a deficit in communication between the Statutory Services and the Voluntary/Independent Agencies (Drug and Alcohol Services, Criminal Justice Rehabilitation Services and National Probation Services, Housing Services), advising their participation in early and statutory intervention processes was crucial in future partnership work to ensure holistic, coordinated planning when working with families with complex vulnerabilities.

Learning Point 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.

117. ***Child S: The Thresholds between Early Intervention, Child in Need and Child Protection between January 2014 and January 2015.***

In this section, relevant contacts and referrals are headed as concerns. The analysis of missing episodes is considered further on in this review and it is positive these episodes were consistently notified to Children's Social Care in late 2014 and during 2015. The overview of these concerns/events/episodes provide a comprehensive picture of escalating neglect. Child S had to accommodate these events and find survival strategies, resulting in the emergence of negative behaviours as a possible response. Thorough consideration of all information from multi-agency partners and direct observation of the child and family is crucial to build an accurate picture of the child's life experience. In 2014 before Child S became subject to child protection proceedings there is no assurance that the holistic picture of the child's life was fully understood by all multi-agency partners and at times it appeared that events were assessed in their own "*silos*".

118. In January 2014, Children's Social Care cancelled a CIN meeting.[31] In early February 2014, there was liaison between School Nurse and school regarding the support on offer and the school describe this as a CAF meeting. There was some inconsistency in the terms used by multi-agency partners interchanging the terms CAF and CIN. This creates confusion in practice and the process to be followed when working with thresholds of child concern.

Learning Point 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.

[31] See description of Child in need in glossary.

119. *Concern 1:* Late in February 2014, significant evidence of neglect was evidenced including; maternal non-compliance with interventions, Child S wandering the streets late at night and low attendance at school, all of which were discussed within a CIN meeting. The mother was not in attendance but may have been in custody at that point. It was unclear which agency was leading the process and there was an action for the family support worker to have a "*talk*" with a Social Worker. Education professionals thought this communication would be a referral but it is not clear whether this was logged as a contact or referral or what was the outcome. There was no effective communication with the Services who were working with Child S's mother.

120. *Concern 2:* In March 2014, it became known that Child S's mother had been placed in custody. No arrangements had been made for Child S's care. The Community Rehabilitation Service made a referral to Children's Social Care and Child S was then placed with family members. The Community Rehabilitation Service was not involved in the CAF/CIN process as mum's case was closed following Child S's mother's custodial sentence. The referral led to a single assessment completed by Children's Social Care. The outcome was documented as *"All agency reports have come back with no safeguarding concerns in respect of Child S. However, the child has poor school attendance and mother has not engaged with early help services including CAF and Family First Support Services. School have been advised to continue to monitor the situation and to offer the child ongoing emotional support. Mother advised to seek support from substance misuse agency".* It is recorded that the case was closed by Children's Social Care in April 2014, despite maternal non-compliance with the CAF process and the emerging evidence of the child wandering around the streets at night.

121. *Concern 3:* In May 2014, Child S was seen by an off-duty Educational Professional, shoplifting with mum. The Primary School rang Children's Social Care Emergency Duty Team, however, were then advised to inform the Constabulary. It is not clear what the purpose of this advice was or what outcome was to be achieved. This should have been considered as a significant incident in terms of child concern and should have instigated further assessment of the child's welfare. At this point the MASH was evolving but there is no evidence that this information was processed through the MASH or that the Children's Social Care Safeguarding Unit evaluated this information.

122. *Concern 4:* In June 2014, another contact was made by the Primary School, to the Local Authority Duty Team when Child S was seen in the pub late at night. The school was advised to speak to Child S's mother and speak to the landlord of the pub. There is information that Children's Social Care Safeguarding Team received this information but no evidence that further action was taken.

123. *Concern 5:* Child S had also been reported missing by the mother prior to this concern and evidence was available from the Constabulary about the child mixing with older children. In July 2014, following discussion with the School Nurse, the school made a formal child protection referral about concern 4. Another single assessment was completed 2 weeks later. There is evidence that information was gathered from the School Nursing Service but no evidence that other agencies were asked for information. The case was not escalated into statutory child protection or CIN processes despite the new information. There was no evidence to indicate that any other intervention was undertaken by multi-agency professionals except for 1:1 work with Child S by the School Nursing Service.

124. During practitioner conversations, there were discussions about the 1:1 work undertaken with Child S. It is positive that the School Nursing Service was keen to undertake work with Child S. However, the service did not have sufficient capacity, specific resources or training to undertake

this work. The School Nurse obtained resources following discussion with line management. Line management discussed the low capacity within the School Nurse establishment, which is also reflective of the national picture. The School Nurse undertook an initial piece of work, then undertook further work with Child S after the child protection plan was put in place and again after Child S became a looked after child. The effectiveness of the sessions was difficult to evaluate, as several sessions were cancelled due to the child's low school attendance rates and the intervention became no longer productive. This work was handed over to Barnardos for completion. The motivation of the School Nursing Service to provide this intervention is commendable however there are significant challenges for agencies delivering such work without adequate capacity or a clear framework and adequate training. The School Nursing Service is well placed to support CSE within the school population[32] however more specific and targeted pieces of work with children living with or at risk of abuse will require a more structured, bespoke approach. The School Nursing Service will need to have the capacity, training and supervision to undertake such work. The reflections within the practitioner event highlighted the broad public health role of the School Nursing Service compared to other multi-agency practitioners whose roles have more specific remits.

Learning Point 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.

125. *Concern 6*: Early in October 2014, Child S had started a local Secondary School (LA2), disclosed hunger and was given food by the Teachers. In mid-October 2014 Child S was caught shoplifting during school hours, attendance at school had deteriorated and Child S's mother was not participative. The child later disclosed, to a foster carer, that shoplifting was the way the child got the food and clothing required for everyday life. Such resources were non-existent at home. It is positive another referral was made to Children's Social Care by the school, however the school did not receive feedback or ask for feedback. There is no evidence regarding the outcome of this referral. There is no evidence that the Constabulary in attendance at the shoplifting event made a referral to Children's Social Care.

126. *Concern 7:* In mid-November 2014, Child S attended school in a very distressed state. The child made significant disclosures about the neglectful life at home and attendance at School was poor. The Teachers documented that Child S presented as "*unclean and smells*", the child's shoes had holes in them, was scared as mum was not well and had refused to go home. The School made another referral to Children's Social Care. The case was overviewed by a Team Leader and discussed within the more established MASH. A formal request was made by the Constabulary for a strategy discussion, due to concerns the child might be at risk of significant harm. Child S was returned home, following a visit to the child's mother who said she was using amphetamines, struggling to manage Child S's behaviour and needed help. The outcome was the environment was concerning but not at the *"level of neglect".* A section 47 [33] investigation was completed and the school were informed by the Social Worker the case would be closed. The school verbally challenged the decision believing that Child S was at risk of significant harm but did not activate the escalation policy.

[32] PHE, DoH (2015) Helping School Nurses to tackle Child Sexual Exploitation. School Nurse programme.
[33] See glossary for description of Section 47 investigation.

127. *Concern 8:* Late in November 2014, the school contacted Children's Social Care, due to concerns that Child S's risk taking activities were increasing and had concerns the child may be at risk of CSE. A visit was undertaken and the concerns regarding CSE were not felt to be substantiated. At this point the new specialist CSE team was in a developmental phase, although not yet fully operational.

128. *Concern 9:* In November 2014, Child S (aged 11 years) also took an accidental overdose of paracetamol. The child attended a local hospital and informed the hospital the case had been closed to Children's Social Care the previous day. The Social Worker however later confirmed to the hospital that the case remained open, pending the outcome of the assessment. The hospital did not at this point refer the child to CAHMS for further assessment which was a missed opportunity at the time. The child later disclosed to the maternal grandmother that the child had not taken an overdose and had just said that to be able to leave the school.

129. *Concern 10*: Early in December 2014, the school reported an incident when Child S's mother came into school and was very unpleasant with Child S. Mother was shouting saying she had had enough of the child, she kept hitting the child on the arm and swearing. The child was very distressed during the meeting and then returned home with the mother. Children's Social Care undertook a home visit. The home conditions were poor and Child S went to stay with an adult cousin that night. The family expressed concerns regarding the mother's drug misuse. The next day Children's Social Care convened a planning meeting to develop a multi-agency CIN plan with the School Nursing and Education Services. Another referral was made to the new CSE team due to concerns about Child S's risk taking behaviour and increasing missing from home episodes. There is no evidence that Adult Services were included in these discussions to provide insight into the challenges the mother faced and support the assessment of her capacity to change to be able to provide good enough parenting.

130. Child S remained in the care of the cousin for approximately 11 days but following a missing episode was returned to the mother's home by the Constabulary. At that point the cousin said she could not have Child S at the home and expressed concerns regarding the child's inappropriate internet activity with older males. The child remained with the mother. Children's Social Care requested a strategy meeting which was convened 1 week later. Several no access visits to the mother were documented in this period.

131. *Concern 11:* Early in January 2015, the CIN meeting was cancelled, reportedly due to Child S's mother's non-compliance. Whilst parental participation is always preferable, parental non-compliance should not postpone the planning process for children who are living with such stressful and unstable factors in their home life. Two days later, Child S was distressed in school, expressing concerns for the mother's health. The school contacted Children's Social Care. A home visit identified further deterioration in the child's environment. Child S was seen alone. The child understood possible options to go back to the cousin's home if needed. Child S however felt safe with the mother.

132. There is no clarity as to how the placement with the child's cousin was assessed to be in the child's best interest, given the cousin's disclosed difficulties in managing Child S's risk taking behaviours and the overcrowding in the property necessitating the child to sleep on a couch at times. It is uncertain where Child S stayed that night, as a friend reported the child had not been able to stay at the maternal grandparents or cousin's home. The cousin and mother reportedly had refused to allow the child to stay. The child's mother contradicted this perspective saying the child had stayed at home then gone missing. There is no evidence that this arrangement was subject to any oversight or contractual arrangements, as should have been the expectation

given the level of risk for the child. There is reference at this point the case was discussed with Children's Social Care line management and a strategy meeting was requested. Following this incident, a strategy meeting was convened 2 days later, with a decision to proceed to a child protection conference which was convened 2 weeks later. During the intervening period the child had a very unstable home life, living between the family home and relative's homes, which were perceived often as overcrowded.

Learning Point 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.

133. During practitioner conversations, the context of the child's experience in relation to historic long term abuse and neglect was understood. Many of the professionals had long term knowledge of the family. In 2014, there was a good transition to Secondary School from Primary School. The professionals in attendance at the practitioner event highlighted Primary School was very nurturing in relation to Child S and extremely child centred. Additional information, received during practitioner conversations highlighted that Child S has previously been well presented at Primary School and was always well dressed in clothes that the other children would have wanted to wear. The Learning Mentor rang the mother to remind her about school and would collect Child S for school if necessary. The school would usually give the child breakfast. The grandma and maternal aunties also provided some level of care including feeding and clothing Child S when the mother wasn't coping. It was difficult to maintain this level of support within Secondary School and concerns were raised about Child S soon after commencing Secondary School.

Good Practice Point 18: The Primary School (LA2) were very child centred and provided a very nurturing environment for Child S and then supported the transition in Secondary School

134. Whilst the intervention provided within Primary School was clearly child centred and focussed on improving the well-being of Child S, the intervention may have hidden the neglect and abuse the child was enduring daily whilst living at home. The challenge for professionals, when acting as a corporate parent, is to understand when the threshold for significant harm is met. Child S's mother didn't attend Primary School for 8 months; therefore, early intervention work was possibly ineffective. This could have been a missed opportunity to escalate the case into statutory processes. Primary School practitioners were not in attendance at the practitioner event so this point was raised from other agencies perspective.

Learning Point 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.

135. The case was worked under early intervention, through CAF arrangements for part of the time, despite evidence the threshold for statutory intervention was met. Multi-agency professionals and managers discussed the challenges for universal services in managing this process, especially in respect to the lack of administrative support and undertaking the lead professional's role. This lack of capacity and understanding, was evident in the information reviewed, the process was confused with no clear lead professional allocated to coordinate the

case. The limitations in involvement by all services and the weakness in participation by Adult Services was evident within the CAF process. The Local Authority has now made improvements to this process, however the role and function of multi-agency partners should be reinforced to ensure they fulfil their responsibilities. The practitioner conversations highlighted a lack of understanding regarding the role and remit of the newly established Early Help Team within the Local Authority.

Learning Point 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.

136. Despite Child S's low attendance rates and only just having started the school, the Secondary School, was extremely proactive in developing an early positive relationship with Child S, who then made some very significant disclosures. The school was also proactive in communicating and raising concerns with Children's Social Care and challenging outcome decisions. There was less evidence that other agencies understood their role in challenge or escalation of concerns through managing case disagreement processes.

Learning Point 31: The LSCB should be assured that all multi-agency partners understand and can escalate their concerns through the local managing case disagreement guidance. [34]
Good Practice Point 19: In 2014/15 the local Secondary School (LA2) 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

137. Professional bias may have been a factor in understanding professional behaviours, in that most professionals unknowingly maintained their belief that Child S's mother would be able to provide good enough parenting, despite the evidence to the contrary. This is known as a confirmation bias, [35] when practitioners tend to maintain their intuitive belief, despite the evidence to the contrary. Practitioners become attached to their judgements and can employ strategies to ensure that new and challenging evidence is not recognised or gathered. The dominant view of the professionals can result in an outlying view being ignored. Most multi-agency professionals did not provide challenge, preferring to leave key decision making and accountability to the lead agency rather than active involvement, which is known as the bystander effect. It is crucial therefore to counteract this belief that all multi-agency professionals receive effective safeguarding supervision for all cases that are drifting within the continuum of child concern.

Learning Point 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.

138. During 2014, there was an accumulation of indicators to demonstrate that Child S was at risk of significant harm. These indicators should have been analysed as part of an ongoing assessment and prompted escalation into child protection or care proceedings at a much earlier

[34] See LSCB Multiagency Child Protection Standards, Sept 2015.
[35] Kirkman E, K Melrose K (2014) Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door' system, Research report, April 2014, The Behavioural Insights Team, DFE.

stage. Child S was left for too long, living with neglect, without any effective ongoing multi-agency support or intervention. The child's risk taking behaviours began to escalate, placing Child S at risk of harm and CSE. Practitioner conversations also highlighted that on reflection in 2014/2015, this case should have been escalated much sooner into statutory child protection processes, although this had not been considered at the time.

139. During 2014, it is not obvious that Child S had been subject to formal CIN processes, as the term was used interchangeably with the CAF. In December 2014, it is clear the child became subject to more formal CIN arrangements. There was limited multi-agency line management scrutiny of the case. There have been several recent changes which will improve multi-agency working in future cases like this. These include a revised thresholds document and step up and step down processes for child concern cases. This will ensure that cases will be subject to more scrutiny, for example, the Independent Reviewing Officers will now monitor the CIN plans in place after the case has been stepped down from child protection plans. During the review process practitioners advised the Local Authority had worked to address low capacity in the Social Work establishment, which had resulted in the overuse of temporary agency staff during the timeline of this review. In the latter 6 months of the timeline, the children's workforce had been fully staffed and practitioners noted Social Work stability was having a positive impact on current frontline multi-agency safeguarding practice.

Good Practice Point 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.

140. In January 2015, when Child S became subject to child protection proceedings the process appeared to work effectively in contrast to the early intervention and CIN processes. A protection plan was formulated; core group meetings were held and the case was quickly escalated into care proceedings following legal consultation.

Good Practice Point 21: The Child Protection pathway was robust and implemented as per the expected pathway when the decision to proceed to case conference was agreed. The risk of significant harm was recognised through effective assessment.

141. The review of the chronology and further practitioner conversations has not been able to completely unravel the multi-agency process followed during the review period related to child concern. It has also been difficult to understand whether communications were always mutually understood, between multi-agency partners and Children's Social Care. Safeguarding work, communication and information sharing was not always inclusive of all relevant partners. There is also limited evidence detailing the inclusion of Adult Services who were providing Substance Misuse Rehabilitation Services and Community Rehabilitation Services for Child S's mother. The Local Authority and its partner agencies have an improvement plan in place to address many of the learning points highlighted in this review, when working with the child concern thresholds.

142. ***Child S: Working with Parental/Family Resistance.***
Throughout the review period, multi-agency services made significant attempts to secure positive partnership arrangements with Child S's mother, grandmother and other extended family members. At times the family were instrumental in providing intelligence that led to the recovery of Child S, however at other times it appeared the family may not have notified or

delayed notification to Children's Social Care or the Constabulary (Police Force 1) of the child's whereabouts.

143. There is also significant evidence that multi-agency partners, especially Education and Early Prevention Services attempted to work in partnership with Child S's mother at an early stage, however this work was challenging and frequently ineffective. Intervention in the home environment was difficult due to maternal behaviours, so was moved to the local Children's Centre. Unfortunately, during this time Child S's mother was also required to meet the requirements of the rehabilitation programme ordered by the Criminal Justice System, maintain contact with the Community Rehabilitation Service and manage the CAF/CIN /child protection/care proceedings. There are numerous examples of Child S's mother failing to engage with services and being hostile or resistant to the help being offered. Conversely there are other occasions where she appeared distressed and unwell and actively sought help from professionals, especially Education with whom she had developed reasonable working relationships. There was little evidence provided of any sustained improvement in her capacity to provide safe, appropriate care for Child S and professionals clearly articulated this during conversations. However, despite this it is positive that professionals continued to attempt to work in partnership with Child S's mother.

144. The evidence provided limited assessment of the mother's parenting style. It did not provide sufficient analysis of her capacity to make the sustained changes necessary to be able to prioritise her child's care, prior to the instigation of statutory processes. There was no apparent consideration of the mother's own history of parenting or experience of significant events. This may have supported greater understanding of her resistant and sometimes aggressive presentation. Child S's mother had significant vulnerabilities which required support and intervention from a range of Adult Services. The Adult Services each had intervention plans which Child S's mother would be expected to comply with. It was perhaps an unrealistic expectation that Child S's mother would be able to comply with multiple programmes of intervention given the multiple and complex vulnerabilities in her life. Practitioner conversations highlighted that the Adult Services were not fully included in the child protection, or CAF processes so often they were not aware of the impacts of the parental behaviour on the child. The Adult Services advised that at times they could have possibly supported the planning for the child, especially when the mother was thought to be harbouring Child S. Adult and children's services should consider the benefits of a single assessment process when planning services to meet the complex needs of such families. This will ensure the provision of planning and intervention is realistic and avoids "setting Child's S's mother up to fail". There is now an Engagement Policy which provides support to practitioners in such cases.

Learning Point 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, Community Rehabilitation/Probation Services) 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.

145. Working with resistance requires all practitioners to have highly developed interpersonal skills as well as the ability to manage their emotions effectively to prevent either collusive or overly oppressive styles of interaction. There is no evidence that the supervision processes explored the impact of working with parental resistance on the practitioners and the effect that this could have on professional responses. Active reflective supervision that fully engages practitioners in

the process, considers the worker/client relationship and uses analysis to identify strengths and weaknesses in practice should be the preferred model in safeguarding work.

Learning Point 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.

146. ***Child S: The Looked After System and an Evaluation of Missing from Home/Care/Education Episodes.***
In July 2014, the first recorded missing episode reported by mother, was documented, whilst Child S was still at Primary School. Child S was known to be "*streetwise*" although and there is evidence that from an early age was used to moving around the locality, frequently without parental supervision, visiting friends and family. Child S's missing episodes escalated in length and intensity during the review period, with the transition into the LAC system, being a notable period of concern. The motivation for Child S's missing episodes often related to wanting to be in a familiar environment, near to peers, boyfriends and family members. Concerns for the mother's wellbeing, would also be a trigger for the child to return home.

147. In the review period, there were at least 19 documented missing episodes and 14 of these were notified to the local Missing from Care Coordinator (Police Force 1). The local coordinator did not have access to the intelligence regarding reported missing episodes when Child S was placed outside the area (LA2). In some instances, missing episodes were not reported as the child returned or was found. It was difficult for carers and professionals to anticipate when an episode would occur. Some episodes were impulsive and opportunistic whereas others were planned during outings i.e. visits to the Children's Centre and the Health Centre. The child would "e*scape*" through any possible route i.e. through windows.

Learning Point 35: Currently local systems (Police Force 1) 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 (Police Force 1) enabled this information to be shared.

148. In June 2015, Child S (aged 12 years), went missing overnight, whilst in foster care (LA2), following disagreement with foster carers regarding the removal of a mobile device and enforced supervision in the use of the internet. In the return interview, the child did not disclose the child's whereabouts during the episode. Constructive conversations between the Social Worker and the child were noted, during which time the risks of CSE were highlighted. Child S agreed to a referral to undertake further work with Barnardos.

149. In July 2015, following a series of missing episodes, another overnight episode occurred, whilst in foster care (LA2). The child had been excluded from school for 2 days following, an aggressive incident with another child and was upset as had missed a school trip. Child S then went missing during a shopping trip to a local shop. The child was found the following day by the Constabulary (Police Force 1) in LA1, following receipt of intelligence from a peer. Intelligence was received that Child S had been in a hotel drinking alcohol and taking drugs, although the child reported staying with a friend. The Constabulary (Police Force 1) undertook an investigation scrutinising the hotel CCTV tapes to identify possible offences/perpetrators. The foster carer was advised to take the child to the local sexual assault and referral centre (SARC), for an assessment due to distress and the risk of self-harm following this event. The child was not examined for a sexual assault but was assessed by a Community Paediatrician,

who concluded the child was not at risk of self- harm and the distress was due to an impending placement move. Advice was given to the child regarding smoking cessation. The role of SARC services in the management of CSE will be discussed later in this review.

150. Professionals became increasingly concerned that the child's mother and family were obstructing the strategies to keep Child S safe. Professionals were concerned they were harbouring the child, not disclosing the child's whereabouts and providing the child with money and mobile devices which enabled the child to access the internet. A meeting was coordinated with the family to reinforce the measures being taken to keep Child S safe and the importance of the family complying with these arrangements. The family were given clear messages about the expectations of their roles and that child abduction notices would be served if the family members breeched the agreement. The messages were reinforced by a letter.

Good Practice Point 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.

151. In August 2015, the child went missing whilst accompanied by mother, during a visit to the General Practitioner. The child was missing from care for 2 nights. During this period the child was in contact with family members, although these contacts were described as opportunistic by the child and family members. During this period the child posted pictures on the internet and appeared to be drinking alcohol and referred to the use of "magic",[36] although denied this on return. The child discussed with the foster carer feeling anxious and was concerned the child had the same mental health problems as the child's mother. Three days later the child went missing again and when recovered was taken to a local police station. The child did not want to return to the foster placement. A police protection order (PPO) was secured and the child was placed in a bridging foster placement (LA1) pending a placement with more experienced foster carers in a cross boundary local authority (LA3), around 80 miles away, the following day.

152. In August 2015, direct contact between Child S and family was suspended and the Local Authority applied for the section 34 Order to suspend contact. Telephone contact was supervised by foster carers who would document telephone contacts, any issues and Child S's responses to telephone contacts. Practitioners advised that it was thought that Child S had some additional contact with family members and was using mobile devices which could not be found during searches as they were hidden on the child's body.

153. Child S attended a new Secondary School (LA3) in September 2015. On a day during that month the child was taken to school by the foster carer but didn't turn up for class and went missing. The child had tried to return to LA2 in a taxi, to visit the family. The taxi driver telephoned a family member, who communicated with Children's Social Care (LA2). The taxi driver was advised by Children's Social Care (LA2), to return the child to the foster placement. This was evidence of a good coordinated response, securing the child's safe return. Between September 2015 and December 2015, the frequency of missing episodes reduced significantly whilst the child was placed with foster carers in LA3. The foster carers were experienced and very proactive in relation to managing Child S's missing episodes e.g. by locking doors and by

[36] Magic is the term used for the stimulant drug Mephedrone belonging to the chemical family of the 'cathinones' group of drugs. Cathinones are a group of drugs related to amphetamine compounds like speed and ecstasy. It was originally sold over the internet as a 'legal' alternative to drugs like speed, ecstasy and cocaine.

following if the child insisted on leaving the premises. The child settled into the placement, enjoying new relationships, outings and activities. The child was given increasing levels of freedom, progressing to being able to go and meet friends. The school quickly assessed the child's educational needs, putting a plan of support in place to improve the child's attainment and to support the child in everyday school life.

Good Practice Point 23: Whilst living in LA3 Child S experienced a period of stability. Agencies worked together well across the boundaries. The experienced Foster Carers (LA3) 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.

154. In November 2015, the Secondary School received intelligence that the child was planning a missing episode. Plans were made between the Foster Carers and the school for the child to return to the foster care placement, to minimise the risk. The child was known to have money, having reportedly borrowed it from new school friends. Three days later, Child S went missing with another vulnerable child, after arriving at school. An immediate appeal was put on a social media site by the Constabulary (Police Force 2) and the child was recovered in LA1, 3 days later. A Recovery Order was applied for, due to concerns that family members were harbouring Child S. Child S returned to the foster carers in LA3.

155. In December 2015, placement plans were made to move Child S to a specialist residential and educational placement nearer to home. The Secondary School felt unable to keep Child S safe and the child was being educated at home. The foster placement had to increasingly resort to" locking" the child in and in recognition of the restrictions this would place on the child's movements Children's Social Care had planned to seek legal orders through the High Court.

156. In late December Child S was placed in an out of area specialist residential and educational placement (LA6) but went missing 2 days later. Child S was not found until 10 days later, however went missing again from the establishment (LA6) on return the same day. Child S was then not found for another 8 days, despite a national alert and media reporting. Child S was then placed in a Specialist Residential Unit (LA4) in early 2016 with 2:1 supervision initially.

157. The Constabulary's (Police Force 1) Missing from Home Coordinator and the Local Authority's Social Worker identified during practitioner conversations that there had been a difference of opinion at one point which was resolved through constructive challenge and discussion. The Constabulary advised that secure accommodation was needed to keep Child S safe and the Local Authorities' view being that an appropriate residential unit should be identified. It was good practice at the time with the Local Authority maintaining their position and found the appropriate residential unit which had specialist learning and therapeutic services on site. There were very regular meetings during this time and high level strategic support. The consensus was clear in that in terms of placing a child of this age (aged 12 years), the ideal is foster care, residential if foster care isn't possible and secure accommodation would only be used as a very last resort.

Good Practice Point 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 (LA2) were clear in their position regarding the preferred placement for this age of child.

158. There is good evidence that expected processes were followed to try to recover Child S. During the period of 2014-2016 (LA2) Children's Social Care reviewed and amended their missing from home/care procedures. All meetings met the specified time scales stipulated by policy. Procedures were followed and missing/strategy meetings were convened, sometimes daily. During the latter missing episodes, a few new strategies were undertaken to try and recover the child, which are not routinely sought. A recovery order was obtained by Children's Social Care. A specialist in finding missing persons was employed to assist in the search for Child S using the same tools available to the social workers. They were carefully instructed not to use covert surveillance tools to identify where the child was. A legal meeting was convened to give consideration for secure accommodation and the possibility of obtaining a civil order giving non-secure placements the ability to enforce restrictions on the child's liberty was considered. On an occasion, secure transport was arranged to collect Child S from the police station and take the child to a new placement, to reduce risk and chance of the child running away again.

Good Practice Point 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.

159. The review identifies that the arrangements for managing missing from care/home/education were robust and often successful in recovering the child. The management of missing episodes is complex and multifaceted requiring professionals to be able to manage the individual cases within a process framework. Professionals were innovative in trying to use new ideas to recover the child, which should be evaluated for use in other cases. Professionals highlighted that when working with vulnerable children, at risk of CSE who are in a high risk missing episode, there can be a lack of planning time resulting in placements that may not be ideal. Practitioners advised there is potential for "*contingency planning*" when dealing with the high-risk victims/missing at risk of CSE. In effect a trigger plan should be in place should another missing episode or a placement break down occur.

Learning Point 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.

160. ***Child S: CSE Managing the Risk and Offender Disruption Activity.***
Prior to October 2015, the management of CSE in LA2 was coordinated through the Missing from Care Coordinator (Police Force 1). The specialist Multi Agency Child Sexual Abuse Team was established locally after October 2015. This service has continued to develop and has received significant investment in response to the emerging and expanding agenda. A few CSE referrals were made in respect of Child S during the timeline of the review before and after the development of the specialist service.

161. The evidence identifies that whilst Child S was still at Primary School (aged 10 years) there were early concerns expressed to the School Nursing service that the child's knowledge base re sexual activity, early patterns of missing episodes, lack of maternal protective factors and the child's presentation gave rise to concerns that Child S was at risk of CSE. There was no firm evidence to confirm this perspective. The concerns were based on professional intuition and understanding the norm of children's development. Early intervention work was undertaken with Child S, to reduce the risk when engaged in risk taking activities, to keep the child safe.

162. In November 2014, Child S was initially referred for assessment due to concerns regarding CSE, following peer disclosures. The child was assessed as low risk. The concerns could not be substantiated and the young people who had disclosed information about Child S's activities would not talk to the Constabulary (Police Force 2). The case was closed. A multi-agency plan was developed to support the child and reduce the risk in respect of CSE. In December 2014, as Child S became subject to CIN arrangements, another referral was made in respect of CSE concerns. The case was assessed as low-risk as there had been no disclosures from the child and was closed. Child S remained in the thoughts of the Constabulary (Police Force 1) as they continued to work with the child's mother and gained intelligence about the child's activities. Further referrals were made in March and June 2015 prior to placement in LA3. An assessment tool to support the assessment of risk had been introduced, however professional intuition also played a significant factor during the management of the case. The case was closed however the risk issues relating to CSE remained a constant consideration for professionals supporting Child S.

163. Referrals were made for support to Barnardos to undertake direct work with Child S locally and when the child moved to LA3. There was a waiting list in LA3 for the intervention by Barnardos, however it is positive consultation was provided to the professionals engaged in work with Child S. Close communication occurred between the key workers and Barnardos to prevent duplication in the intervention with Child S. In LA2, Barnardos were a part of the team providing the service however during practitioner conversations concerns were expressed that this aspect of the service is to be de-commissioned. The LSCB should be assured that the effectiveness of alternative provision and expertise is quality assured.

Learning Point 37: The LSCB should be assured that post the de-commissioning of Barnardos within the specialist CSE service the alternative provision is quality assured and can offer the necessary expertise. (LA2)

164. In October 2015, Child S disclosed that the child had been raped in early in 2015, the offender alleged to be a 14-year-old child. The Constabulary (Police Force 2) undertook an investigation and the significant event was alerted through the internal reporting systems due to the alleged perpetrator also being a child. There has been no prosecution in respect of this episode. Child S disclosed further sexual activity had occurred in early in 2016, with a different young adult. Child S disclosed this activity was consensual and to date does not believe a sexual offence has occurred. The Constabulary locally and in cross boundary areas have investigated these incidents however the evidence has not been sufficient to proceed to criminal proceedings in respect of either incident.

165. Key professionals discussed the joint approach to support victims of CSE. If the case is designated as a child protection concern the key workers build relationships and trust with the child. The specialist CSE team now offers advice and consultation to key practitioners and overviews the management of the case. A significant challenge for the specialist CSE team will be how they engage in work with young people who are not assessed as high risk, when applying the risk assessment tool, yet their behaviours clearly place them at significant risk. These cases are often closed to the team. The high-risk rating on the tool is often reflective of a disclosure/prosecution relating to CSE i.e. a significant event has already occurred therefore the child has been significantly harmed. Equal expertise and intervention should be targeted to children bordering this threshold to provide much earlier, targeted and individualised intervention to prevent that first significant episode of CSE occurring. The consideration of an early psychological assessment could support this intervention process. Universal and Adult

services are in a good position to hypothesise which children within the population present the greatest risk of CSE.

Learning Point 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. (LA2 and LA 5)

166. In the longer term LA2 has plans for the engagement and management of CSE victims in its work. The management of CSE locally is now subject to regular evaluation and improvement. LA2 has made improvements to strengthen the local arrangements including arrangements to overview and manage the cases of local children when placed in cross boundary areas. In February 2016, the LSCB initiated a CSE diagnostic process as part of a LSCB regional performance framework process and has developed an improvement plan to strengthen the process.

167. ***The Health of Child S.***

The review has been unable to secure relevant medical information in respect of Child S's and the mother's general health. This case therefore reflects the learning from the previous serious case review in that communication and partnership arrangements with General Practice should be strengthened to encourage participation in the case review processes. Work has been undertaken locally to encourage participation. GP Practices are now being asked to provide reports for case conferences and are now made aware of children subject to Child Protection or LAC plans. Child S was not known to have any long term medical conditions requiring ongoing medication or treatment and had the required LAC statutory health reviews. Child S had rare attendances at urgent care centres and no known hospital admissions.

168. In July 2015, following a missing episode, Child S was taken to the local children's SARC centre, was assessed by a Community Paediatrician, who concluded the child was not at risk of self-harm and that the child's distress was due to an impending placement move. Advice was given to the child regarding smoking cessation. The SARC's learning review advised that this was a missed opportunity to escalate the case and recognised that within the service there had been a lack of understanding in relation to CSE and limited learning opportunities. This resulted in difficulties in achieving a standardised approach. The service has made recommendations to strengthen the understanding of CSE within the service. It has now developed improved feedback to multi-agency partners in respect of children who present with risk factors that place them at increased risk of CSE. Multi-agency arrangements should consider strengthening the inclusion of the SARC service at an earlier stage in case management when children are at risk of CSE. NHS England [37] has recently reviewed the role of SARC services nationally and within the report identifies the role SARC services have in the management of CSE.

169. The health of Child S was reviewed as per guidance and the School Nursing Service despite significant capacity issues could keep track of Child S and was clearly actively involved in multi-agency work to reduce the risk of harm. This has been previously described in this review.

170. Child S attended a local Accident and Emergency department in November 2014 following an alleged overdose. The service was not aware at that point that the child later disclosed the story

[37] NHS England (2015) Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services.

had been made up to get out of school. At the time the hospital knew the circumstances and should have taken into consideration that this child was only 11 years of age, with no previous history of self-harm, living with neglect and involved in some risk-taking activity. The assessment process should have considered a referral for risk assessment of the child's mental health however no referral was made. Early in 2015, as part of the CIN plan a discussion was held with the CAMHS service regarding a referral for Child S. The service advised the referral was not indicated although there is no understanding provided as to why this consultation was thought to be necessary. Child S presented as a mature and *"streetwise*" child, however living with neglect for many years may have compromised the child's emotional development, placing the child at increased risk of abuse of CSE. The child may not have understood the risks faced. Therefore, it is crucial that specialist services such as CAMHS see the child in their holistic situation rather than viewing and making their decision based on the impact of one event. The involvement of CAMHS and psychological services has previously been discussed in this review.

171. ***The Role of Education.***

The role of education has been highlighted positively throughout this review. During the timeline of the review process Child S transitioned from primary to secondary school education establishments. These establishments were without exception extremely child centred. Child S was regularly provided with food and clothing to meet the child's basic needs when conditions at home had deteriorated and education staff made significant attempts to work in partnership with the child's parent and alternative carers such as family members and foster carers to improve the outcome of interventions for Child S.

172. There was also considerable evidence that education worked well and shared information with multi-agency partners. This continued as the child moved into cross boundary areas despite the challenges this brought to the communication processes with the key workers. Child S's education attainment was of significant concern and there were highlighted plans put in place to secure improvements especially when the child moved to LA3.

3.3 Child S: Conclusion

Table 3: Analysis of interacting risk factors (focusing on factors known at the time of the trigger event). [38]

Background Hazards known at the time	Situational Hazards known at the time
Escalation in MFC episodes Streetwise and appears "*older than years".* Psychological profile unknown i.e. emotionally immature MFC episodes impulsive although sometimes planned Significant history of neglect (11 contacts/referral in 2014/5) Bereavement and Loss issues Disorganised and ambivalent attachment to mother. Low attendance in education Shoplifting as a survival technique Disclosure of sexual assault/rape Peer disclosures re child's risk taking behaviours Child carer (mother) Presentation indicative of neglect.	Main carer, maternal lone parent with mental ill health, criminality, shoplifting and substance misuse issues, living in poverty. Parental non-compliance with interventions relating to; criminality, drug and alcohol and parenting. Extended family inconsistent in partnership work with CSC and support to the family Extended family harbouring Child S Home environment chaotic and neglectful ***Unknown but suspected*** *Limited basic resources such as food and clothing in the home.*
Strengths/protective factors known at the time	**Dangers known at the time**
Positive and supportive peer relationships On occasions family, would support recovery Close attachments to extended family, cousins and MGM Child could be open in disclosures to professionals in education Positive relationships between child and educational staff. Child communicative in telling the story. No significant behavioural challenges except related to MFC episodes and occasional violence.	Child access to hidden mobile devices Child intelligence re talking to older males on internet Child intelligence re alcohol misuse and possible substance misuse Child x 2 Referrals to CSE specialists> low risk of CSE Child receiving money from family whilst LAC

173. The review has considered whether the events leading to Child S becoming a victim of CSE could have been predicted or prevented. The multi-agency service provision of services across Local Authority boundaries has been critically appraised to identify that if information had been effectively and systematically compiled could a prediction of harm have been identified and the risk more effectively managed.

174. Critical reflection identifies the multi-agency management of CSE is multi-faceted and there is not an exact science to determine the root cause for this type of abuse occurring. The case is complex as the child did not and still does not believe that an offence has occurred in relation to

[38] Acknowledgement to Ball K (NSPCC) for the use of the Analysis of interrelating risk factors methodology, contained in SCR Child N, Lancashire 2015, SCR repository.

CSE, has not made a disclosure and there have not been related criminal convictions in respect of offences aligned to CSE. 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.

175. 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. Research provides evidence that children subject to neglect and disorganised attachment are disproportionately victims of CSE due to the risk-taking behaviours developed as a strategy for survival. Therefore, the child's experience of neglect could be a contributory factor in the circumstances that led to the child's experience of CSE. The early intervention processes around the 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 could have undertaken the function. During practitioner conversations, it was highlighted that some universal agencies have capacity issues which result in a lack of administrative support and challenges in undertaking the lead professional's role. It is positive that the local authority has re-designed early help services however all partners should provide assurance that they have the capacity to undertake early intervention work.

176. Professionals remained child centred, irrespective of the child's behaviours They communicated with and endeavoured to ascertain the child's views and wishes. This was especially evident when the child became subject to statutory processes and proceedings. The child was always the focus of professional's intervention and there were many instances when multi-agency professionals engaged effectively with the child to develop positive, nurturing relationships and could stay alongside the child rather than taking an adult focus. Education professionals were keen to ensure the child's basic needs were met and would provide food, clothing and bring the child into school for education. Whilst the motivation was clearly to support the child it may have "masked" the child's experience of neglect. Therefore, it is essential that professionals can analyse the impact of their intervention and whether this makes any sustainable difference for the child living with neglect.

177. Partnership with the mother and family was at times challenging but again professionals understood the need to work in partnership and challenge adult behaviours that were not in the child's best interest. This case demonstrates the importance of a single assessment process for adult and children's services, when working with families with complex vulnerabilities. This would benefit more effective care planning and avoid setting the most vulnerable adults up to fail in their quest to provide good enough parenting for their children.

178. 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.

179. The research question is "*How is the LSCB assured that we protect children at risk of CSE when placed outside the borough".* There is significant evidence that despite the challenges in communications across local authority areas, the multi-agency services could work together effectively. The Children Looked After Social Worker and the Constabulary were particularly effective in the coordination of communication and information sharing across the areas which enhanced the quality of intervention for Child S.

180. ***Predictability and Preventability.***

In conclusion when analysing the interacting risk factors (see table 3) the possibility of Child S becoming a victim of CSE was potentially predictable but at the time not preventable. It cannot be absolute 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.

SECTION 4: THEMATIC LEARNING FROM THE CASES OF CHILD Q AND CHILD S.

182. This section provides a summary of the emerging themes arising from these two cases, it will not duplicate the contents of the review. The case of Child Q has not been able to explore the child's experience of neglect however Child S's experience has been explored within the timeframe of the review.

183. ***Child Focus.***

During the review process, there was opportunity to discuss the challenging and sensitive issues arising from these cases with some of the practitioners directly involved with the children. The conversations were insightful and demonstrated the practitioners remained focussed on the children's needs, whilst balancing the complex needs of the adults. At times professionals (Teachers) were faced with significant challenges when a child presented hungry and unkempt, necessitating the provision of food and clothing before the education could begin. There was consistent evidence that frontline professionals, communicated with the children, engaged the children in care planning and encouraged the children to communicate their wishes and feelings. Disclosures were managed and the children's voices were listened to and heard. There was regular praise of the key Children Looked After Social Workers who both developed trusting and enduring relationships with the children.

184. At times, though, the adult's unmet needs were challenging and considerable. The inclusion and participation of adult services may have supported intervention and planning at the time, for a child, especially when the adults were thought to be harbouring the child.

185. ***The Impact of Neglect.***

The children were both victims of long term neglect and abuse, their experience evidenced to have begun in their early years (aged 4 years and 7 years first documentation). The children both had substantial caring responsibilities for either younger children or vulnerable adults and had significant experience of bereavement, separation and loss. The parental carers had complex challenges to manage (mental ill-health, substance misuse, criminality) within their own lives. Their extended families were perceived as protective factors by professionals. In 2014, there was no evidence to provide assurance that the assessment of Child S's extended family as a protective factor for the child was based on an accurate assessment of the family's strengths/weaknesses.

186. In 2006, the assessment of neglect accurately assessed the concerns for Child Q, resulting in statutory processes being invoked. There was a delay in securing permanence, partly due to the court decision in making an order for the child return home to the parents. In 2014, the Child S's neglectful situation was understood by professionals, however statutory processes were not invoked until the child's environment and parenting experience had reached a crisis point. The child by this point had begun to engage in risk taking behaviours and was at significant risk of CSE. It is positive the LSCB has now developed a neglect strategy (2015-2107) and a work programme is currently subject to implementation. In view of recent findings, the LSCB will need to demonstrate the impact the strategy has had on safeguarding practice and outcomes for children, when working with families and children living in neglectful circumstances.

187. ***Prevalence of CSE.***

LA2 developed a CSE strategy (2016) and work plan to support frontline practitioners working with CSE. Practitioners identified that over the preceding 18 months they had received more development opportunities and support regarding working with CSE. This has resulted in

significant and positive changes within practice. However, there is a potential for the CSE data to be captured in different places i.e. children looked after, child protection, criminal justice systems resulting in LA2 not having a holistic perspective of the prevalence of CSE locally within their child population. This will impact on the provision of development opportunities and systems if there is not an accurate assessment of the prevalence of CSE locally.

188. There was evidence of positive federation across agency boundaries between multi-agency partners however currently LA2 is unable to track the child population who are then placed in cross boundary areas. There was evidence that cross boundary Police Forces had access to this information. The Constabulary (Police Force 1) have plans in place to resolve this issue.

189. ***CSE.***

CSE is an emerging focus in safeguarding work and is subject to significant research as organisations attempt to provide effective services and solutions to manage the abuse. Preventative intervention will be crucial in cases assessed as low risk. The thresholds in respect of CSE appear to fall into four main categories;

- Children with no assessed needs in universal services, who require awareness raising, knowledge and information about CSE.
- Children whose circumstances, environmental and parenting factors can be hypothesised to place them at increased risk of CSE.
- Children whose circumstances (as above) and police intelligence raises significant concerns that the children are subject to CSE (no disclosure or conviction).
- Children who have disclosed issues relating to CSE and/or there has been a CSE related conviction secured.

190. These cases demonstrate that practitioners understood the need to undertake 1:1 work with the children. However, intervention was not always aligned to the threshold of concern. At times the same type of work was undertaken, irrespective of the level of concern. The work was frequently badged as 1:1 or Keep Safe intervention. However, there was not always a consistent approach used or access to specialist services such as Barnardos. There was no understanding provided in respect of the planned outcomes or any evaluation of its effectiveness. There is considerable evidence that early intervention work with children at risk of CSE can be effective, if structured and individualised to a child's needs, by an appropriately trained individual/professional. It is positive the evolving team will undertake a significant role in coordinating the aspect of planning in the future.

191. It is notable that Barnardos was originally commissioned locally to provide this level of expertise, however within a short time this service has been decommissioned, in preference to another provider. Re-designing such aspects of service provision has a risk of interrupting progress, as the children then must re-develop relationships with new professionals. The LSCB should be assured that such commissioning decisions are subject to strategic scrutiny and oversight to ensure continuity of service provision for these children.

192. Both these cases identify that the cross-boundary arrangements were well coordinated to manage the risk issues relating to CSE, including perpetrator disruption activity. The Police Forces and the Children Looked After Social Workers were especially active and notable in this area of practice.

193. There were significant challenges in keeping children safe when using social media and the legal restrictions on accessing these sites without the child's permission. The search for hidden

devices was undertaken regularly and these searches were documented. However much more support and focus needs to be given to this area of work to enable front line practitioners and their organisations to "keep up" with the technology and software that could easily identify mobile devices.

194. ***Child Protection vs Child in Need Vs Early Intervention***.
During 2015, multi-agency professionals made regular contact/referrals with Children's Social Care. It was at times confusing for professionals in universal services who were unaware as to which contacts were then accepted as referrals. Some professionals thought that repeated referrals had been made but then closed. There was limited evidence that professionals escalated concerns regarding threshold disagreements. In 2016, during the practitioner events, universal professionals were unaware of the difference between a contact and a referral, indicating that further guidance should be offered to ensure universal practitioners understand the child protection referral system.

195. In 2014, the CAF should have been embedded in practice however there was no evidence that the CAF process was followed. In 2016, practitioners openly discussed the challenges when working with the CAF system. Some agencies could not administrate the CAF system or due to capacity issues undertake the lead professional's role. It is positive that the Local Authority has recently re-organised its early help assessment process. However, other multiagency partners also have a key role in ensuring the intervention is effective through the CAF process. This will reduce statutory involvement in family life. The LSCB should be assured that the early help assessment process is working in practice, it's the cornerstone of a coordinated approach to early intervention and is subject to an improvement plan.

196. Notably there have been several recent improvements in these systems which includes; a revised threshold document and the introduction of step up and step down processes to monitor child concerns cases held within child protection, child in need and early help caseloads. The introduction of the MASH has strengthened the assessment of need through more effective information sharing. There should also be audit of cases held within the CAF process, to reduce the risk that cases are drifting in multi-agency early intervention processes. Effective supervision processes as well as case audit may help assure the early intervention system.

197. ***Children Looked After and restricting a Childs's Liberty.***
These cases highlighted the challenges for foster and residential care providers, across local authority boundaries, in keeping a child safe when the risk of missing episodes is high. Providers were aware and had to make difficult decisions when restricting a child's freedoms to avoid the deprivation from being an illegal action. Sometimes this would conflict with the CSE risk management strategy.

198. During the timeline of this review new case law has emerged which provides greater insight in how to manage these issues. LA2 has responded appropriately to this, seeking legal advice with the intention of applying to the High Court for relevant orders, when restrictions to a looked after child's movements are necessary to protect the child from the impacts of risk taking behaviours and CSE.

199. ***Supporting the front-line staff when working with Children at risk of CSE.***
The practitioner events and conversations were insightful into the passion, motivation, dedication of practitioners and the emotional trauma they faced in their attempts to keep the children safe. It is critical in CSE work to support the workforce through: staff care, supervision, development, learning opportunities and de-briefing following an incident. There are significant

benefits individually and across the workforce if these systems are robust including; a reduced risk of silo working and greater understanding of other agencies roles. Practitioners identified they had access to supervision systems and felt well supported by their line managers. This had improved over the previous 18 months.

200. It was notable that one group of practitioners were subject to regular physical assaults, necessitating attendance at local urgent care centres. This was a rare and unusual experience, following which the staff were provided with the opportunity for de-brief by the manager. The agencies should consider how staff should be supported following a physical assault by a child and the most appropriate NHS services to attend for assessment of physical injuries following an assault in the workplace.

201. ***Missing from Care.***

The system for managing missing from care/home and education has significantly evolved during the timeline of this review. The process appears to be robust locally and across organisational boundaries. There was good cross boundary communication and cooperation between the key statutory agencies. Episodes were clearly documented and regular strategy meetings/discussions occurred. Policies were reviewed and updated. Analysis of missing episodes was evidenced and return interviews with the child were always undertaken. The system primarily is worked by the Constabulary and Children's Social Care and on occasions key multi-agency professionals were unaware of missing episodes. The Role of multi-agency partners needs to be clarified.

202. ***Securing Placements for Looked After Children at risk of CSE.***

These cases identified the challenges in securing stable specialist placements for children looked after, who exhibit at times extremely challenging or violent behaviour. The children have made progress following the CSE events, having been placed initially in residential placements with 2 specialist carers. Stability has been secured. This may be an option for children looked after who exhibit extremes of behaviour, to enable a period of stability at a much earlier point in their journey. Many of the placement changes occur because of a significant event, when there is limited opportunity to plan. Contingency planning may be advantageous for such cases.

203. ***Strategic Leadership.***

The review of these cases highlighted that line and strategic senior managers were actively involved in supporting the management of these cases. A notification system has been developed to alert senior managers to high risk child protection cases. This reporting system should also include children at high risk of CSE. Practitioners highlighted the benefit of senior managers having oversight and scrutiny of such cases and felt supported by the senior manager's interventions.

204. ***A Psychological Approach and Understanding Behaviours.***

The children each developed strategies to survive their environments. They were both described as streetwise and appeared older than their chronological age. The likelihood is that both children were in fact emotionally developmentally immature due to their life experience. The children were "very troubled" and may not have fully understood the risks they faced. The survival strategies resulted in behaviours that were extremely disturbing and challenging for professionals. Professionals were subject to assaults by a child.

205. The commissioning of independent psychological expertise was a positive approach, to support greater understanding of the child. This led to the development of an individualised behaviour management plan, coordination of the plan across the multi-agency partners and offered

consultation to all the professionals involved. The child's response was positive, then the child was moved to an out of area placement.

206. There remains some confusion in practice as to when a case meets the criteria for CAMHS intervention, as opposed to other types of therapy. At times one of the children was involved with 3 differing professionals, all wanting to have direct intervention with the child. The pathway to access emotional, psychological or mental health services should be reviewed to ensure multiple interventions are not implemented causing confusion for the child.

207. ***The Use of Restrictive Practices.***

This has been discussed within the review. One of the children was subjected to high levels of physical restraint and LA2 had policies in place to use two differing methodologies. This meant that the child was subject to differing practices in school and within the Residential Children's Home. The LSCB should be assured restrictive practices/restraint techniques are appropriate, consistently applied and in line with national expectations when managing challenging behaviours across all multi-agency partnerships.

SECTION 5: LSCB RECOMMENDATIONS

The LSCB should;

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.

SECTION 6: APPENDICES

Appendix 1: The Serious Case Review Process

1. The Background to the Serious Case Review Process.

In July 2015, the Chair of the LSCB and the SIRG discussed Child Q's case. The outcome decision was to undertake a multi-agency learning review. The National Panel were notified and challenged this decision, believing the criteria for a serious case review was met. The LSCB reconsidered its decision and in September 2015 agreed to commission a serious case review in respect of Child Q. The review was commissioned in December 2015 using the principles per national guidance [39] and regulations.[40] The child had been seriously harmed and there was cause for concern as to the way in which the authority, LSCB partners and other relevant persons had worked together to safeguard the child.

In January 2016, the Child Q serious case review was underway when the file relating to Child S was reviewed by the LSCB Chair and the SIRG. The decision was to commission a serious case review as; Child S had been missing for two extended periods prior to the child's 13th birthday and in the view of the SIRG and LSCB Chair had therefore likely suffered serious harm whilst in the care of the Local Authority.[41] The review was commissioned in April 2016. The LSCB Chair and SIRG advised that combining the learning from both case reviews would enhance the learning and advised the National Panel of this intention. The subsequent challenge by the National Panel and the LSCB response to this are described in the foreword section of this report.

The multi-agency services spanned six Local Authority areas (referred LA 1-6), and four Police Forces. Predominately two Police Forces with CSE Specialist Teams (Police Forces 1 and 4) provided the intervention to Child Q and Child S.

LA2 is the Local Authority area holding statutory responsibility for the welfare of both Child Q and Child S. Within the timeline of the serious case reviews the Local Authority and LSCB were subject to an Ofsted inspection of its services for children in need of help and protection, children looked after and care leavers and a review of the effectiveness of the LSCB. The authority is currently implementing an improvement plan in response. This review will not make duplicate recommendations to those in the improvement plan.

The LSCB did not request a specific methodology to the completion of the review but was eager that the process should analytically review relevant practice events and systemic issues throughout the agreed timeline. Good practice and areas requiring development were to be noted leading to the development of recommendations and an implementation plan. A thematic section was to include the combined learning from each case. Child Q, Child S, their families and professionals' participation was to be encouraged. A hybrid methodology has been applied, combining several

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[39] HM Government (2015) Working Together to Safeguard Children- a guide to interagency working to safeguard and promote the welfare of Children. Crown Copyright. Downloaded www.gov.uk 18.10.2015.

[40] Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews.

[41] HM Government (2015) Working Together to Safeguard Children- a guide to interagency working to safeguard and promote the welfare of children. Crown Copyright. Downloaded www.gov.uk 18.10.2015

theoretical, tested models and techniques. [42] [43] [44] The LSCB provided the following research question for analysis; "*How is the LSCB assured that we protect children at risk of CSE when placed outside the borough"*.

The definition of CSE remains subject to national consultation at the time of writing. The consultation has been undertaken due to increasing concerns regarding the variety of definitions used and the resulting confusion within safeguarding practice, including the completion of risk assessments and in the collection of data.[45] It will be important for the LSCB to review the definition in line with the expectations of national guidance as the agenda around CSE evolves.

This review applies the definition used locally [46] and nationally [47] at the time the cases were active which was:
"*Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. CSE can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability."*

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 Case Review Team and Panel Members.***

The LSCB convenes a new case review panel for each serious case review. Panel members were supported by the LSCB administrative support officer. Panel members were required to demonstrate their independence and nominated a deputy to ensure continuity in the process. Independent legal advice was available to the panel through a Legal Advisor.[48] The cross boundary LSCBs were invited to participate and support the work of the lead LSCB (LA2). The Case Review Team, SIRG and LSCB quality assured the content of the overview report. The panel members were;

- Designated Nurse: Independent SCR chairperson.
- Independent Reviewer (author) and an Independent Reviewer shadowing Child S case.
- Constabulary (Police Force 1).
- Head of Service, Child Protection: Children's Social Care (LA2).

[42] Welsh Government (2012) Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Model.
[43] SCIE Learning Together to Safeguard Children: a systems model for serious case reviews.
[44] HM Government (2015) Working Together to Safeguard Children- a guide to interagency working to safeguard and promote the welfare of children. Crown Copyright. Downloaded www.gov.uk 18.10.2015
[45] Gov.UK, February 2016, Statutory definition of Child Sexual Exploitation, closed consultation.
[46] Child Sexual Exploitation Multi-Agency Strategy 2014-2017 (collaboration between 9 local authorities sharing boundaries)
[47] Safeguarding Children and Young People from Sexual Exploitation: Supplementary Guidance to Working Together to Safeguard Children (DCSF, 2009).
[48] See appendices declaration of involvement.

- Education Improvement Officer (LA2).
- Senior Solicitor Legal Advisor.
- Designated Doctor: Local Children's Hospital (LA2).
- Youth Offending Service Manager: Youth Offending Team (LA2), attended initial meeting.
- Associate Director: Independent Children's Residential and Education Group, Independent Sector (LA5).
- LSCB Business Manager (LA5)
- Administrative Support Officer.

3. ***The Combination of the Overview Report.***

The Case Review Team advised that the same review methodology should be applied for each case to ensure consistency. Each case was reviewed independently. The evidence was collated; individual chronologies were developed and practitioner events/conversations were held separately for each case. Agencies then produced individual learning summaries and action plans. The overview report analyses each child's experience separately. It considers the learning achieved over the timespan of both reviews including the improvements and emerging themes to strengthen practice. It makes a conclusion followed by recommendations for future practice when working with children at risk of CSE.

All multi-agency partners reviewed the case, learning summaries and action plans were only produced if agencies considered new learning opportunities were evidenced. This is a new system which will need ongoing scrutiny to ensure multi-agency partners adequately support the serious case review process and effectively critically analyse safeguarding practice within their own organisations.

Learning Point 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.

4. ***Terms of Reference.***

The review focussed on the research question provided by the LSCB, "*How is the LSCB assured that we protect children at risk of CSE when placed outside the borough"* and terms of reference were established (see table 1).

Table 1: Terms of Reference.

Number	Terms of Reference.
TOR 1	Was relevant historic information about the child and their family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances?
TOR 2	Was the child protection plan/looked after child plan or other pathway plan robust, appropriate, effectively implemented, monitored and reviewed and was the multi-agency contribution evidenced in the development and delivery of the plan?
TOR 3	To what degree did agencies challenge each other regarding the effectiveness of the plans, including progress against agreed outcomes for the child?
TOR 4	Were the respective statutory duties of agencies working with the child and their families fulfilled?
TOR 5	Were there organisational or contextual obstacles or difficulties in this case that prevented agencies from fulfilling their duties?

5. ***Collation of Evidence.***

A comprehensive multi-agency chronology was collated for each child, highlighting key practice incidents and themes. These chronologies are not included in the review but were critical in the development of timelines to evidence key practice events and emerging themes. Agencies were asked to provide information between January 2013 to February 2015, predating the trigger event for Child Q. The timeframe for information in respect of Child S was November 2013 to January 2016. All agencies were requested to summarise relevant historic information for each child. The combined information enabled significant insight into cross boundary and local multi-agency safeguarding practice between January 2013 and January 2016.

Agencies submitted learning summaries with action plans and undertook ongoing rapid appraisal during the review process, to ensure action plans were instigated immediately when system failures were highlighted. The LSCB received an interim briefing to ensure multi-agency strategic leaders were fully briefed on the emerging themes to influence current service developments. Practitioners events and conversations were convened and documented for each case.

6. ***Anonymity.***

National guidance is currently not prescriptive about maintaining anonymity within the content of the overview report. However, LSCBs are required to consider the potential risk and impact on children, families and practitioners when releasing identifiable data within the final publication. The LSCB is keen to protect the identity of the children, their families and multi-agency employees therefore, this report will minimise the disclosure of personal and identifiable information. A genogram has not been included to reduce the risk of identification. This is in line with the legal expectation not to publish the identity of sexual offence victims during their lifetime without their informed consent. The themes and events will be discussed in a style which minimises the risk that either child's or family's identity will be unintentionally revealed. Multi-agency employees will be described in respect to their job role, to protect their anonymity and to encourage open and honest reflection of their safeguarding practice.

7. ***Child Participation.*** .[49]

Direct conversations with Child Q and Child S were postponed until the children were stable in their presentation and able to make an informed choice about their contribution. The review panel has maintained close contact with their key workers to facilitate the children's contribution and to ensure they are fully informed regarding the progress of the review. In December 2016 Child Q participated in a conversation which enhanced the child's perspective in the case. Conversations with Child S are planned when the child is more settled.

8. ***Family Participation***.

The case review panel acknowledges that over a short period both families have had to accommodate a series of extremely traumatic events which have notably changed their family dynamics. The case review panel considered the participation of key family members could make an important contribution to the learning from the review. The families' Social Workers were asked to support the planning of communication with the families of Child Q and S. Conversations have now been held with Child Q's mother and aunt and Child S's mother. children.

[49] Morris K, Brandon M, Tudor P, (2013). Rights, Responsibilities and Pragmatic Practice: Family Participation in Case Reviews, Child Abuse Review, Published online in Wiley Online Library (wileyonlinelibrary.com)

9. ***Practitioner/Manager Involvement***.

An event was facilitated for practitioners and their managers in respect of each case to enrich the information in the timeline and develop key lines of enquiry. The events were positively evaluated by the attendees, enabling significant reflection on practice issues. Additional practitioner conversations and communications were convened as necessary to clarify issues raised throughout the process of the review. The content of the overview report will be shared with the practitioners and their managers prior to publication. Education professionals and foster carers were not participative in these events due to a variety of reasons. This should be strengthened to support their participation.

Learning Point 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.

10. ***The Independent Reviewer***.

Jane Carwardine became an Independent Safeguarding Consultant in April 2015 following an NHS career spanning 42 years. This is her third serious case review. Jane holds a MA in Child Care Law and Practice (Keeled) and a BA Honours in Health Studies (Bolton). Her professional background is in nursing (Nurse, Health Visitor and Midwife), as well as holding strategic, provider and commissioning management roles. She has had 15 years dedicated experience in a variety of safeguarding leadership roles including; senior and line management functions, Designated Nurse for Safeguarding (including adults and children) and Head of Safeguarding. Examples of her safeguarding activity includes; supporting the completion of serious case reviews, leading on multi-agency safeguarding learning and development, assuring the quality effectiveness of safeguarding activity, complex case management, the development of multi-agency teams, developing supervision systems, development and leadership of safeguarding advisory teams, membership on safeguarding boards and providing advice to a range of strategic boards. Jane has been directly involved in the completion of more than twenty serious case and multi-agency learning reviews. She has worked intensively to improve the quality effectiveness of the serious case review process and has represented until recently the Royal College of Nursing on the Royal College of Paediatrics and Child Health Child Protection Committee. She has not been employed by any organisation aligned to this review.

Appendix 2: Glossary & Bibliography.

Ambivalent Attachment	Ambivalent attachment develops when a caregiver is inconsistent in her emotional and physical availability to the Child; at times the caregiver is accessible and at other times is preoccupied. This discrepancy causes the child to remain focused on the caregiver, actively seeking her attention by behaving in a fussy or clingy manner. **Downloaded 30.7.16 www.forever-families.com Copyright Carol Lozier 2012**
Building Skills for Recovery	This programme offers people who have been using one or more substances a route out of dependency with a strong focus on recovery. The holistic approach used in the programme centres on the needs of each individual participant and considers the variety of factors which has brought them to this point in their life. Participants may join the programme immediately and this has shown to be effective in supporting recovery. A personalised plan is drawn up, working with the participant in the individual sessions before joining the group. There are 16 group work sessions and 3 one-to-one sessions. If specific needs are identified such as family breakdown or alcohol awareness, extra sessions may be given.
CAF	Common Assessment Framework: is a standardised approach to conducting assessments of children's additional needs and deciding how these should be met. It promotes more effective, earlier identification of additional needs, particularly in universal services and aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development.
CAMHS	Child and Adolescent Mental Health Services are specialist services that offer assessment and help when children and young people have emotional, behavioural or mental health difficulties.
Child Abduction Notices	Different legislation, applicable in different parts of the UK, defines different offences of child abduction, kidnapping, abduction and child stealing. An offence of 'child abduction', as defined by the child abduction act, 1984, can only be recorded for victims under the age of 16. Child Abduction Warning Notices (CAWNs) are used to disrupt an adult's association with a child or young person. Previously called 'Harbourer's Notices', a CAWN warns the adult they have no permission to associate, contact or communicate with the young person, and if they continue to do so then they may be arrested and prosecuted. The use of CAWNs is attracting increasing attention. In 2012 the Office of the Children's Commissioner asked the Government to extend their use to include children up to the age of 18 (rather than 16) and to allow them to be served without parental consent where necessary. This year Barnardos published the findings of a parliamentary enquiry into CSE and trafficking which recommended strengthening the legislative basis for CAWNs and subsequent breaches. **Downloaded11.6.16: http://www.childabduction.org.uk/images/site/one-cause-logo.png**
Child in Need	Section 17 of the Children Act 1989 defines a child as being in need if: He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without

	provision of services from the Local Authority, His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority, He or she has a disability. The definition includes any child or young person under the age of 18. The service can also be provided to the child's family or any member of his or her family, so long as the aim is to safeguard and promote the child's welfare. Support can include providing cash assistance to a family. Local Authorities are under a general duty to safeguard and promote the welfare of all children in need in their area. They must do whatever possible to ensure sufficient services and measures are in place to promote a child being raised within its own family, if it is safe to do so. The authority is obliged to offer the following specific services/support for children in need in their area: Advice, guidance and counselling; Occupational, social, cultural and recreational activities; Home help (including laundry facility); Facilities or assistance with travel to and from any services provided under the Act or similar service; Assistance to enable the child and the family to have a holiday. **Downloaded 24.11.15 from protectingchildren.org.uk**
Child in Need (CIN) meeting	If children's social services decide the child is in need they will draw up a plan, setting out what extra help they will provide to the child and their family. This is called a child in need plan. The plan should say when and how the plan will be reviewed
Clinical Psychologist and Systemic Psychotherapist	This is a combined role covering two areas work; Psychologists assess and treat children and adolescents. They help children cope with stresses like divorce, death, and family or school transitions. Children may have a variety of developmental issues, from learning disabilities to severe mental illness. A partial list of problems treated includes attention deficit disorder, autism, obsessive compulsive disorder, phobias, and adjustment disorder. The role supports the optimum diagnosis when a complex set of symptoms is presented. Psychologists are experts in conducting psychological tests. Clinical psychologists normally receive more training in providing long-term mental health therapy. Their programs are more clinically focused than those of developmental psychologists. Clinical child psychologists are considered health service providers, however, their training also prepares them in indirect roles, as Consultants or researchers. In psychotherapy, systemic therapy seeks to address the child not only on the individual level, as had been the focus of earlier forms of therapy, but also as children in relationships, dealing with the interactions of groups and their interactional patterns and dynamics.
Disorganised Attachment	The child can be stuck in an awful dilemma; survival instincts tell the child to flee to safety, but safety may be in the very person/people that are frightening the child. The attachment figure is often the source of the child's distress. The child will often disassociate from themselves. **Downloaded www.psychalive.org 1st July 2016.**

Framework for Assessment	A framework has been developed which provides a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live. This assessment identifies whether the child being assessed is in need, whether the child is suffering or likely to suffer significant harm, what actions must be taken and which services would best meet the needs of this particular child and family. **Further reading** **Framework for the Assessment of Children in Need and their Families London, The Stationery Office.**
Keep Safe Preventative Work	Keep Safe Preventative Work is about teaching children messages to keep them safe from sexual, domestic and all other types of abuse and neglect. It is a project currently under evaluation by the Department for Education and predominately used in schools.
PRICE	Protecting Rights in the Care Environment (PRICE) technique is designed for children aged 12 to 14. It has four phases: prevention, restraint, holding and breakaway. It is described as non-pain compliant. It has three escalating phases of distraction methods based on a series of holds, with increasing numbers of staff involved in each phase. Systematic de-escalation of these holds is said to be central to the technique. Incident reports should be completed for each restraint. **Further reading:** **DoH (2014) Positive and Proactive Care: reducing the need for restrictive interventions.**
Reductionist Theories	Is the practice of analysing and describing a complex issue in terms of its simple or fundamental parts, especially when this is said to provide a sufficient explanation. In child protection work to use this approach creates a risk that the presenting problem is seen as the whole issue at that moment in time rather than seeing the issue as part of a potential set of complex but interrelating issues which need to be managed.
Section 47 Investigation	Is also known as a child protection investigation and is called a "*Section 47"* after the section of the Children Act 1989 which sets out the duty. Children's Social Services have a legal duty to look into a child's situation if they have information a child may be at risk of or has suffered significant harm.
Single Child and Family Assessment	The Single Assessment provides a structured framework for Social Workers to record information gathered from a variety of sources to provide evidence for their professional judgements, facilitate analysis, decision making and planning. A core assessment should be completed within 45 working days of its commencement. A completed record is then used to develop the plan for the child or young person.
SOPO	Sexual Offences Prevention Orders (SOPO's) were introduced by the Sexual Offences Act 2003 (Section104-113). The statutory test is that an order can only be made if a court thinks it is necessary to protect the public or any particular members of the public from serious sexual harm by the defendant. A SOPO is a civil preventative order and can be made by the Magistrates Court or Crown Court. It is made at the point of sentence or by complaint to a magistrate's court, in respect of someone previously convicted of a sexual offence, when that person's behaviour suggests the possibility of re-

	offending. The aim of any such order is to reduce the risk of future sexual harm. **Reference:** **Devas N., (2012) Sexual offences prevention orders after R. v Smith, Chambers of Michael Hubbard Q.C. and Karim Khail Q.C. One Paper Buildings. (Downloaded 26.6.16**).
Start Again Syndrome	Is regularly described in safeguarding research as a professional behaviour in safeguarding work. It occurs when safeguarding assessments are undertaken only in respect of the presenting issue rather than taking into consideration the holistic context of the case and the escalating impacts on the child. Assessment is not viewed as a continuous process and is perceived as one off event. Systems that focus on process rather than professional opinion and experience are contributory factors in the development of start again assessments.
Team Teach	Team Teach is designed to promote de-escalation strategies and the reduction of risk and restraint. It supports teaching, learning and caring, by increasing staff confidence and competence, in responding to behaviours that challenge, whilst promoting and protecting positive relationships. **Further reading:** **teamteach.co. uequ**
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Appendix 3: Child Q: Single- agency recommendations (taken directly from agency learning reviews)	
Organisation	**Action**
NHS Foundation Trust (LA2)	Staff will have the knowledge required to work with children who are at risk of CSE.
Children Social Care (LA 2)	When children go missing the Missing from Home and Care procedure should be followed. When placing any child in an out of borough placement there needs to be a suitability meeting to ensure the placement can meet the child's needs, in addition to ensuring the match with other children in placement is considered. Procedure to be devised and implemented to ensure suitability meetings occur. When children regularly go missing from OOB placement and there has not been any impact from intervention meetings a complex case discussion should be chaired by head of service and a HOS notification should be sent to the Assistant Director. All missing from care strategy meetings should be compliant with working together All missing from care strategy meetings for children placed out of borough should consider the need for agencies to send representative from in borough and out of borough agencies.
Independent Psychology Consultant	Make predictions about longer term consequences of decisions.
Independent Residential Children's Home (LA5)	LSCB learning and development programme to ensure sound knowledge of the missing child protocol (LA5) Continue to build positive professional strong links/relationships with the CSE Team/ missing from home coordinators CSE face to face training for all staff
Cross Boundary Community Provider Services (LA5)	CSE Information regarding how information is shared both inter and intra agency has vastly improved since the introduction of the dedicated CSE nurse post within the central locality. The practitioner has now developed key relationships amongst the networks and acts as a point of resource and contact for staff and is able to ensure that communication is shared proportionality in a timely manner. Cross Boundary Working: This continues to be recognised at a national level as a cause for concern and the organisation continues to work at a strategic level to improve partnership working and strengthen communication methods. Specifically, from this review the intention is to review our Standard Operating

	Procedure (SOP) to ensure that potential gaps in knowledge when working with families who have been in contact with services in other areas is revisited, and where cases are complex additional information is sought if not readily available. CAMHS - As highlighted above a best practice SOP will be considered to ensure that as a service we are able to improve upon our assessment processes for Children and YP who have accessed provision elsewhere.

Appendix 4: Child S: Single-agency Agency Recommendations. (taken directly from agency learning reviews)	
Organisation	**Action**
Rehabilitation services	Service to insist on attendance at meetings even if the child is a looked after child, living out of the area Liaison from the early intervention stage rather than once the case has gone to child protection
Children's Hospital Trust	Safeguarding flow chart to be updated to include consideration of CSE with associated vulnerabilities Feedback from referrals/requests for advice from SARC service
School Nursing Service	Staff will have the knowledge required to work with children who are at risk of CSE. Data regarding children at risk of CSE to be collected via the CSE process Staff to be aware of the links between social media, CSE and Safeguarding. Staff will respond appropriately when a child is missing from home, education or service. All staff to be confident in appropriately escalating cases.
Constabulary	Joint approach to victims of CSE. If designated S47 then use key workers/Social Worker to build relationships and trust. Oversight and management of CSE vulnerable children when outside of the area.
Children's Social Care	12: All relevant actions are contained within the improvement plan

Appendix 5: Collated Learning and Good Practice.

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. (LA2)
3. The Independent Reviewing Officer offered scrutiny, expertise, case knowledge, positive leadership and constructive challenge. This was commended by multi-agency partners. (LA2)
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. (LA2)
5. The residential care staff (LA2) 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. (LA2)
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. (LA2 and LA5)
8. The impact of bereavement on Child Q was acknowledged by Residential Care Workers (LA 5) 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. (LA2)
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. (LA2)
11. The organisational assurance system for the management of restrictive practices when working with children in Residential Children's Homes (LA5) was well organised with clear organisational reporting systems and independent scrutiny.
12. The Constabulary (Police Force 1) 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 Constabulary (Police Force 4) 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 Constabulary (Police Force 4) 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 daily the Residential Care establishments and Education establishments (LA2 and LA5) 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 (LA2) 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 (LA2) 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 per 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 LA3, Child S experienced a period of stability. Agencies worked together well across the boundaries. The experienced Foster Carers (LA3) 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 (LA2) 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. (LSCB LA2)
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. (LSCB LA2)
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. (All LA and LA2 Education)
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. (LA2 but relevant for all LA, Health)
5. The LSCB should be assured that the NHS (LA2) has effective arrangements for transferring the health of LAC information across NHS boundaries. This could be evidenced through audit processes. (LA2 but relevant for all LA and Health)
6. The LSCB should be assured that the focus on the implementation of the neglect strategy is maintained to influence front line practice and improve the short and long-term outcomes for children living with the experience of neglect. (LSCB LA2)
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? (LA2 but relevant for all LA)
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. (LA2 but relevant for all LA)
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. (LA2 but relevant for all LA)
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 can build a safe and trusting relationship with the child. Commissioning arrangements should be strengthened to secure the availability of such places. (LA2 but relevant for all LA)
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. (LA2 but relevant for all LA and health providers and commissioners)
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. (LA2 but relevant for all LA and Health providers and commissioners)
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. (All)

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. (All)

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. (LA2)

16. The LSCB should be assured that the local Constabulary (Police Force 1) investigates 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. (All)

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. (All)

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. (LA2 and LA5)

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; does 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? (NHS LA2)

21. The LSCB should be assured that the NHS (LA2) 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 (LA2 and LA5) 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 (LA2) 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 can 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. (LA2)

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. (LA2)

26. The LSCB (LA2) 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. (LA2)

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. (LA2 education)

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. (LA2 education, health, GP, adult)

31. The LSCB should be assured that all multiagency partners understand and can escalate their concerns through the local managing case disagreement guidance. (LA2 primary education, health)

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. (LA2 health, education)

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/community rehabilitation services) 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. (LA2 Adult services, health)

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. (LA2 all)

35. Currently local systems (Police Force 1) 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 (Police Force 1) 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. (LA2)

37. The LSCB should be assured that post the de-commissioning of Barnardos within the specialist CSE service the alternative provision is quality assured and can offer the necessary expertise. (LA2)

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. (LA2 and LA 5)