Knowsley Safeguarding Children Board

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NEWSLETTER

Knowsley Serious Case Reviews 2016/17 (Issue 2)

This is the 2nd and final edition of the Knowsley Safeguarding Children Board (KSCB) Serious Case Reviews Newsletter of 2016/17. This has been produced for all staff, organisations and agencies working with vulnerable children in Knowsley. I would ask you to read this and the Serious Case Review (SCR) it highlights. I would also ask you to discuss the findings and share the learning amongst your teams, in meetings, development sessions and supervision and decide how it will change and improve practice in the future.

Audrey Williamson
Independent Chair KSCB

The Knowsley Safeguarding Children Board (KSCB) has published the independent serious case review concerning two looked after children who were victims of Child Sexual Exploitation (CSE), Child Q and Child S.

These cases are independent from each other; however, the decision was made by the board to merge the cases into one serious case review in order to increase the learning opportunities in respect of CSE. The primary agencies involved included Children's Social Care, NHS Foundation Trust, Independent Residential Children's homes, education and the police.

Child Q

In 2006, Child Q and their sibling group were made subject to child protection proceedings under the category of neglect. The children became subject to full care orders. After a number of moves, Child Q was ultimately placed in a specialist residential children's home. Child Q could at times present with significant behavioural challenges, which was considered to be an effect of living with long term abuse and neglect, insecure attachments, loss and bereavement and placement instability.

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

Child Q had been missing from care for over 42 hours, having spent the two nights at the home of a registered sex-offender. Child Q had also been communicating with other inappropriate adults, on social media sites. Convictions have been secured against the registered sex offender and other non-related adults in respect of these offences.

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

A large number of lessons and good practice were identified by the independent reviewer.

Please turn to page seven of the Executive Summary document to read the good practice and learning identified within this review: **http://www.knowsleyscb.org.uk/wp-content/uploads/2017/01/Executive-Summary-Child-Q-and-S.pdf**

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We hope you find this newsletter useful and if any of you have ideas you would like to see in future issues, please contact **sarah.herron@knowsley.gov.uk**

Child S

Child S suffered enduring and long term neglect combined with inadequate care and poor parenting. Child S was regularly reported missing from care, school and home. This pattern of behaviour escalated when the child became accommodated as a looked after child, with increasing and longer missing episodes including overnight.

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

Later that year, through to 2016 three referrals were made to the specialist CSE team regarding CSE concerns, these were assessed as low risk. Child S soon after had a number of missing episodes, one which led to a national alert and media reporting.

It was agreed that residential care with appropriate safeguards was most suitable for Child S. 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.

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

A large number of lessons and good practice were identified by the independent reviewer, which are listed in the Executive Summary.

The independent author made five recommendations, which the Board have accepted.

They are:

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

The board accepted the findings of the review and has demonstrated a commitment to learn from the lessons, which are identified in the report.

The independent reviewer has cascaded the learning from this review at our Annual Workforce Conference, which focused on Child Sexual Exploitation and what we have learnt over recent years. Practitioners involved in the review were invited to attend a feedback session; feedback from those who attended was excellent, finding the whole process a really positive experience. One practitioner felt that "The review process and report provides good insight into the day to day life of the child and the challenges faced by practitioners. It also clearly highlights areas of good practice".

You can find published reports, executive summaries and the KSCB response at the following link on our website: www.knowsleyscb.org.uk/professionals/learning-from-practice-scrs-mrs/

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