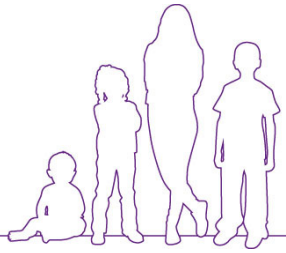
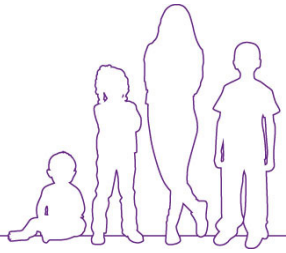
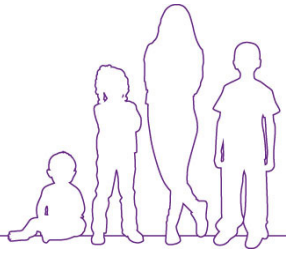
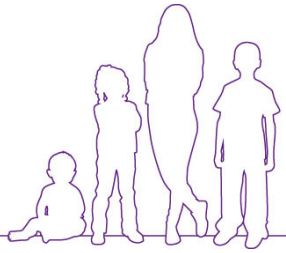
Thurrock
Local Safeguarding Children Board

Serious Case Review:
“Julia”









1 INTRODUCTION TO THE REVIEW PROCESS

Reason for the Serious Case Review

1.1 Julia (14) attended Sexual Assault Referral Centre (SARC) in December 2012 after she made a disclosure of rape. When she was medically examined she was found to have a significant sexually transmitted infection. Julia gave a history of sexual abuse at age 6 and 11 and four recent experiences of being raped, which had been investigated. The Designated Nurse also became aware that there was an extensive family history of involvement with specialist services and historical allegations of sexual abuse.

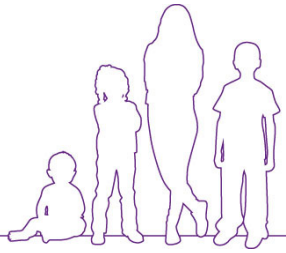
1.2 The Designated Nurse referred the details of Julia's circumstances to the Thurrock Serious Case Review subcommittee where it was agreed that it met the criteria for undertaking a Serious Case Review as outlined in Chapter 8 of Working Together to Safeguard Children 2010 (DSCF 2010[i]).

1.3 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:
(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

1.4 Working Together was reissued in 2013[ii] and provided new guidance for undertaking a Serious Case Review which requires that they should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;

[i] Education Department (2010) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. London
[ii] Education Department (2013) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. London



- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

LSCBs may now use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro[iii]. The Thurrock LSCB agreed to undertake a review using the SCIE Learning Together methodology[iv].

Time scale for the SCR

1.5 Although Julia and her family have been known to Universal and Specialist Services for many years, the SCR Review Team agreed that the period to be reviewed would be from November 2010 – to February 2013 when Julia became subject to a Child Protection Plan.

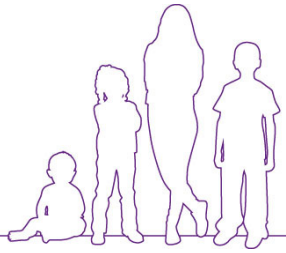
This review was commissioned in May 2013 and completed in May 2014.

[iii] Munro, E. (2011) The Munro review of child protection: final report: A child centred system. London RSO.
[iv] Fish, S. Munro, E. and Bairstow, S. (2008) Learning Together to Safeguard Children: developing a multi-agency systems approach for case reviews. SCIE. London

Julia's Family – all names have been changed for reasons of confidentiality

1.6

	Relationship to Subject	Age at start of review process – November 2010	Ethnicity	
Julia	Subject of the review	12	White/ British	School
Sophia	Mother	39	White/ British	Working
	Non resident father of Julia - left the family in 2000. (Julia is not supposed to have contact because of concerns about allegations of his sexual offences against children. He now has a new family and Julia has visited them in the past)	39	White/ British	Not known
Natalie	Half sister (her partner also lived in the family home in the period under review)	18	White/ British	College
Courtney	Half sister	16	White/ British	College
Paige	Half sister	15	White/ British	
	Non resident father of Natalie, Courtney and Paige left in 1995 – unclear if there is any current contact.			
Little is known about Julia's wider family, but that Julia remains in contact with her maternal grandparents and her uncle, and Julia's mother said that she has a difficult relationship with maternal grandmother.				



Succinct summary of case

1.7 The background to this case is a long history of contact with children's welfare and child protection services for Julia, her siblings and parents. Julia's mother and her father were known to children's welfare services as children. Julia was assessed as having special educational needs for which she receives additional support at school. Historic health records report that as a child Julia's mother was also considered to have learning difficulties, but no formal assessment has ever been undertaken, so the precise nature of these difficulties remains unclear. There has been long standing concerns about Julia and her half siblings regarding neglect, intra-family sexual abuse, physical abuse, domestic abuse and social exclusion/deprivation. These were addressed by a large number of referrals from Universal Services, Assessments, Child Protection Conferences, Child in Need processes, therapeutic support and police action. Over time there were concerns about the parent's lack of engagement with services, but there was also evidence of sufficient change in the lives of all the siblings, which led to Children's Social Care feeling able to withdraw from involvement with the family.

When Julia was aged 12, in January 2010, she disclosed that she had been raped, she made three further disclosures of rape by boys (aged 15- 18) over a two year period, and despite good police investigation it has not been possible to achieve a prosecution.

Over this period there were also periods when there were concerns about her poor attendance, behaviour and anger at school, and her mother complained about her behaviour and angry outbursts at home. As a result of Julia's disclosure of rape in December 2012 Julia was made subject to a Child Protection Plan in February 2013 and Julia's mother has also engaged with the Troubled Families project.

Timeline of critical incidents

1.8

Earlier contextual information	
Date	**Incident**
January 2010	Children's Social Care received a referral from the police about allegations that Julia had been sexually assaulted by a male friend.
February – March 2010	A Core Assessment was undertaken under Child Protection Processes (Sec 47 Children Act 1989) by Social Worker 1 and concluded that there were concerns about the sexual assault, but Julia was no longer at risk of harm. A Child in Need Plan was formulated and Julia and her family were transferred to a social work team.
June 2010	Police conclude that they do not have enough evidence to pursue a conviction.
July 2010	The Team Manager of the social work team contacted Safeguarding to query why there had been no Child Protection Conference for Julia. The electronic records provide no evidence of a response.
July to November 2010	The allocated Social Worker 2 attempted to contact the family, via numerous texts, letters and unannounced home visits without success.
Review Period Starts	
Date	**Incident**
3 November 2010	School report to Children's Social Care that Julia had told them she had sexual intercourse with a boy who was a friend. The allocated Social Worker 2 tried to make contact with Julia's mother without success, and also contacted the police who visited the family home that evening.
4 November 2010	School contacted Julia's mother and suggested she take her to the GP.

9 November 2010	Julia visited GP 1 with her mother and was prescribed contraception. The concerns about the sexual assault were discussed, and the GP agreed to contact the police. There is no recorded evidence that this happened.
November/December 2010	During November and December many attempts were made to contact Julia and her mother by Social Worker 2 without success. The Social Worker 2 and her Manager agreed a Strategy Meeting should take place, and the police agreed. The Social Worker pursued this without success.
13 January 2011	A home visit was undertaken by allocated social worker 2 and police officer 1. Julia was seen with her mother. The police said that the rape disclosure was not supported by the available evidence, and there could be no further action. A referral to the Sexual Health Advisor and support activities for Julia was taken forward.
February 2011	The Sexual Health Advisor attempted to make contact with Julia without success. Social worker 2 was also unable to make contact despite many calls and home visits.
March/April 2011	Children's Social Care considered closing the case because of lack of engagement, but continued to try and make contact with Julia and her family.
May 2011	A referral to Children's Social Care was completed by the Accident and Emergency Department of the hospital regarding concerns about lack of appropriate parental care and an injury to Courtney. An Initial Assessment was completed about Courtney, by Social Worker 2 and recommended case closure with referrals to parenting support and family mediation to address family conflict.
June/July 2011	Julia's mother sought support from Social Worker 2 regarding Julia's disruptive behaviour and concerns

	about sexual contact with boys. Referrals were made to parenting support and the Sexual Health Advisor by social worker 2. Mother also told GP 2 that she was concerned about Julia's disruptive behaviour and the GP made a referral to Child and Family Consultation Service (one of the services of CAMHS). No other agency was informed of this referral.
8 August 2011 – September 2011	Children's Social Care sent a letter saying the case had been closed, but reviewed this decision because of a referral received in September 2011 which meant that the case remained open until January 2012.
4 September 2011	Julia was given a final warning for an incident where she had thrown boiling water over her sister Courtney. Courtney went to hospital with her mother who told hospital staff that Julia had been sexually active since the age of 11. They appropriately made a referral to Children's Social Care. A Core Assessment was undertaken by social worker 2 and concluded that there were no concerns regarding Courtney, and no need for services, but Julia would need further support which would be provided by the school and Coram would provide parenting support to her mother.
6 September 2011	The social work Team Manager sought advice for a second time from the Safeguarding Team because she thought a Strategy Meeting should be convened and a Child Protection enquiry carried out. There is no evidence in the records of a response to this request, or that any further action was taken.
September 2011	Julia's mother attended three sessions of the parenting programme, but did not complete the programme.
17 October 2011	Julia had her Annual Review meeting for a student with a Statement of Special Educational Needs at school, and concerns about her poor attendance and behaviour were discussed, goals were set in these areas.
November 2011	Julia attended a sexual health drop in session at school

	with the School Nurse. She said she was having sexual contact with a 14 year old boy and her mother was aware of this. She was assessed as Gillick competent and contraceptive advice and support was given, in line with existing health guidance.
December 2011	Social Worker 2 was unable to make contact with Julia or her family and the school and Social Worker shared information. School said they were concerned about Julia's attendance and behaviour/aggressive outbursts.
January 2012	Julia continued to have difficulties at school and support/ counselling was provided by the Learning Mentor. The school struggled to contact mother. The Social Worker 2 made many attempts to contact and visit Julia and her family without success.
31 January 2012	Case closed to Children's Social Care.
February – May 2012	School remained concerned about Julia's anger and behaviour, and made a referral to Children's Social Care regarding bruising to Julia's sister. There is no evidence in the electronic files or school records of a response to this referral.
May 2012	Julia and her mother saw GP 2 twice regarding the contraception pill and once for advice regarding mothers concerns about Julia's behaviour.
June and August 2012	Julia's mother contacted the Duty Social Work Team twice for advice about managing Julia's behaviour, sexual behaviour and her wanting to meet boys. On the second occasion Social Worker 3 visited, but there was no one at home because the family had gone on holiday. A letter was left asking mother to make contact, but she did not.
October 2012	During the course of an investigation of sexual assault of another young woman, the police were told that Julia had also been raped by the same perpetrator. The police interviewed Julia and she alleged that she had

	been raped. When interviewed again by the police she said that it had been consensual and she had previously had sex with six other boys. The police made a referral to Children's Social Care and a Core Assessment was initiated. This assessment was not completed before a further disclosure of sexual assault was made by Julia in December 2012. School were concerned at this time about her poor attendance and disruptive behaviour.
8 December 2012	Julia reported to the police that she had been raped by a 19 year old man. She was seen at the Sexual Assault Referral Centre where she was diagnosed with a sexually transmitted infection by the Doctor who examined her. She was seen by the nurse who made a referral to Children's Social Care because she was concerned about Julia and her mother's attitude regarding the infection.
12 December	Julia was seen with her mother at the Genito-Urinary Medicine Department of Sexual Health (GUM) for treatment, where she told the Doctor that she'd had "*15 to 20 sexual partners*". The nurse at the clinic also made a referral to Children's Social Care. Julia's mother did not take Julia to the follow up appointment to treat the sexually transmitted infection.
14 December/11 January 2012	Julia was seen with her mother at home by Social Worker 4 and the sexual assault was discussed.
December 2012	The Inclusion Leader from the school and Lead from the Troubled Families Project visited the family, they were concerned that the house was in a poor state of repair and the three sisters were huddled in bed because there was no heating.
18 January 2013	Children's Social Care convened a Professionals' Meeting to discuss progress regarding the rape disclosures made by Julia. Three appointments with the police were cancelled by Julia's mother. At this point

	Julia's attendance at school was 50% and there was ongoing conflict with peers at school.
January 2013	The Core Assessment was extended to include the second rape disclosure and was completed by Social Worker 4 in January with a recommendation of Child in Need support from the social work team.
29 January 2013	The case was allocated to Social Worker 5 and she requested (with the support of her Team Manager) that an Initial Child Protection Conference be convened. This was held on 21 February 2013. Julia was made subject to a Child Protection Plan.

Methodology

1.9 This serious case review has been undertaken using the SCIE Learning Together methodology[v]. The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper, underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case, and changing them should contribute to improving practice more widely. Data comes from semi-structured conversations with the involved professionals, and the young person and their family who are the subject of the review, from case files and contextual documentation from organisations. A fundamental part of the approach is to talk with staff to understand what they thought and felt at the time they were involved in the case, avoiding hindsight as much as possible. It is vital to try and make sense of what factors contributed to their understanding at the time and to the decisions they made. This is known as 'local rationality'. Any appraisal of practice is then made in the context of those contributory factors.

[v] Fish, S. Munro, E. and Bairstow, S. (2008) Learning Together to Safeguard Children: developing a multi agency systems approach for case reviews. SCIE. London

The Lead Reviewers

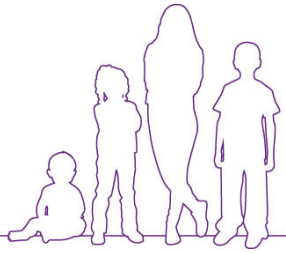
1.10 This review was undertaken by Jane Wiffin (Independent Lead Reviewer) and David Peplow, both of whom are SCIE accredited Lead Reviewers.

Jane Wiffin was the Independent Lead Reviewer. She is a qualified Social Worker who has extensive experience of working in safeguarding. She is an experienced serious case review author and chair, having undertaken 18 reviews. She was accredited as a SCIE Learning Together Reviewer in 2011 and has undertaken a number of reviews using this methodology. She is currently engaged in work developing tools and frameworks for addressing childhood neglect and she is an experienced auditor and safeguarding trainer. She is independent from all the agencies involved in this review.

David Peplow served 25 years as a police officer. He was the Essex Police lead for safeguarding matters and Head of Child Abuse Investigations. He has extensive experience of multi-agency working across three Local Authority areas. He left the police in 2012 and became an accredited Learning Together reviewer in July 2012. He is the Independent Chair of Thurrock LSCB and sits on a fostering panel. David is independent of all the agencies involved in this. Although he is Chair of the LSCB he has undertaken this serious case review from a critical and analytical standpoint.

The Review Team

1.11 The review was conducted by a team of senior representatives from local agencies who has had no direct involvement with the case. They shared in the conversations, the analysis of documents, the identification of key practice episodes and contributory factors. This report is the shared responsibility of the Review Team in terms of analysis and conclusions, but was written by the joint lead reviewers.



Name	Agency
Yvonne Anarfi	Designated Nurse for Safeguarding Children: NHS Basildon & Brentwood CCG /NHS Thurrock CCG
Sandra Bryan	Matron for Disabled Child Team for North East London NHS Foundation Trust
Julie Cole	Lead Consultant for Safeguarding and Quality: Coram
Liz Chapman	Manager – Operational Investigations: Essex Probation
Kathie Clibbens	Professional Lead & Consultant Nurse Safeguarding Children: West Essex Clinical Commissioning Group
Anita Erhabor	Associate Designate Nurse: Basildon and Brentwood and Thurrock CCGs
Lesley Ford	Detective Chief Inspector Head of Child Abuse Investigation & Police Online Investigations Teams / Head of Child Safeguarding
Barbara Foster	Head of Care & Targeted Outcomes, Children's Directorate, Thurrock Council
Cassandra Moore	Named Nurse for Safeguarding Children, Basildon Hospital
Lindsey Marks	Principal Solicitor for Children's Safeguarding; Thurrock Council
Malcolm Taylor	Principal Educational Psychologist

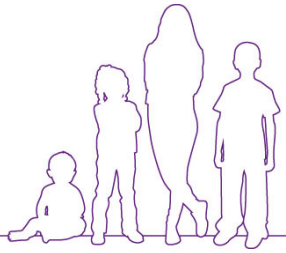
The Case Group

1.12 The members of the Case Group are the professionals who worked with or made decisions about the family, and who had individual conversations with members of the Review Team. The Case Group comprised of over 20 people (although not all these people attended Case Group meetings). Most were briefed on the methodology and then met with the Review Team on four further occasions to share in the analysis, the identification of contributory factors, and to comment and contribute to the report. Individual sessions were held with some professionals, either because they could not make the Case Group meetings or to clarify data.

- Two Social Workers
- Social Work Team Manager
- School Liaison
- Special Educational Needs Coordinators
- School Nurse
- Three police officers
- Two nurse specialists
- School counsellor and school support
- Education Welfare Officer
- GPs
- Practice Manager for GP surgery
- Parenting Workers
- Specialist Doctor
- Inclusion Leader, School

Family Member Involvement

1.13 Julia and her Mother contributed to the Review by meeting with the Lead Reviewer on two occasions, once at the beginning of the process, and once at the end.



Structure of the Review Process

1.14 The Review Team met on six occasions, including four times with the Case Group, and worked with them on the information from the conversations to the identification of the Findings and issues for LSCB consideration.

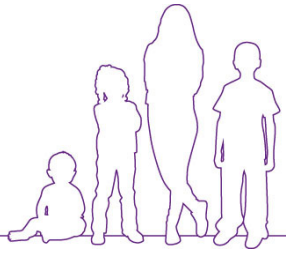
Sources of data

1.15

- The semi-structured conversations between members of the Review Team and 20 members of the Case Group;
- The semi-structured conversations with family;
- Documentation: All necessary documentation was made available to the review ranging from case files, procedures, and police attendance records. This meant that the reviewer did an in depth review of all the relevant information held during the period under review by Children's Social Care, GP surgery, Police, School Nurses, Coram, school, GUM and SARC.

About Thurrock

1.16 Thurrock lies to the east of London on the north bank of the River Thames and within the Thames Gateway, the UK's largest economic development programme. Thurrock has a strong manufacturing and retail focused economy. There is a very significant regeneration programme centred on five growth hubs: Purfleet, Lakeside, Grays, Tilbury and London Gateway. Thurrock has a resident population of approximately 40,200 children and young people aged 0 to 18, representing 25% of the total population of the area. In 2012, 25.7% of the school population was classified as belonging to an ethnic group other than White British compared with 22.5% in England overall. Some 12% of pupils speak English as an additional language. Deprivation levels in Thurrock are consistent with the national average, but there are significant pockets of deprivation and inequality, with several areas falling within the 20% most deprived areas in England.

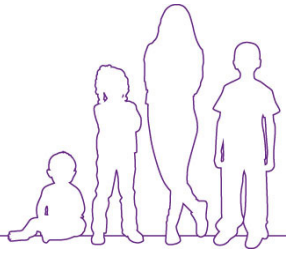


2 APPRAISAL OF PROFESSIONAL PRACTICE IN THIS CASE

2.1 A Serious Case Review plays an important part in the efforts to achieve a safer Child Protection system. Consequently it is important to consider what happened and why in a particular case, but to then go further and reflect on what this might reveal about underlying gaps and strengths in the child welfare system that may reappear in other cases. This case should act as a "window on the system" and move beyond the case specific. We begin by capturing the appraisal of the practice response to this case, given what was known and knowable at the time. The Findings that follow in the next section then aim to provide an explanation of the "why", outlining what got in the way of professionals being as effective as they wanted to be.

2.2 It is difficult for those professionals who were directly involved with Julia and her family to have practice they were involved in appraised in this way. They were very open to reflecting on practice, but wanted to make clear that some of what took place is historical, and some aspects of the practice reviewed has now changed and developed. The Review Team is grateful to them for being open and helping to make sense of the case and the context in which practice took place. It is clear that all individual professionals cared about what happened to Julia and her family. Many of the professions involved, for example the allocated Social Care Team and the police, were overloaded in the period under review and this had an impact on practice in this case. Less is known about whether there were capacity issues for the other services involved.

2.3 During the timeframe for this review (just over two years) there were four critical incidents, three of which were disclosures of rape and sexual assault by Julia and one related to concerns about the quality of physical and emotional care that Julia and her siblings received. There was an immediate response to most of these incidents. However, on occasions, established policies and procedures were not followed, including a Strategy Meeting/discussion, Child in Need



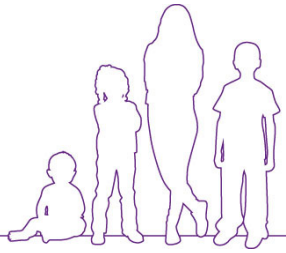
processes, processes for non-attendance at school and evidence that some health professionals did not make direct referrals to Children's Social Care, although there is also evidence of good multi-agency referrals too.

2.4 Beyond these points of crisis, despite a lot of professional activity and concern, there was little progress in improving the safety and wellbeing of Julia and the professional responses appeared to 'drift'. It is the task of this review to consider why this was so, and what this tells us about the strengths and weaknesses in the multi-agency Child Protection system.

Working with persistent non–engagement

2.5 In part, the lack of progress for Julia was as a result of the passive resistance by Julia's mother to most professional contact and help. Many agencies spent a great deal of time trying to see Julia and her family without success and Julia's mother regularly missed meetings, did not follow up on referrals made for her daughter's well-being and failed to return telephone calls or reply to letters about failed appointments. There was a mistaken belief that Julia could not be seen without mother's permission.

2.6 The only time that contact with mother was possible was when there was a crisis, or she wanted advice about Julia's difficult behaviour as she saw it. As soon as the immediate crisis had been addressed, Julia's mother withdrew, meaning that Julia did not have contact with professionals and was unable to develop helping relationships with them. The cause of this withdrawal by mother was insufficiently analysed or challenged, and no solution was found to address it. The school were aware of Julia's poor attendance at school and held meetings to discuss this with Julia's mother. Although they discussed the potential for taking formal action, none was taken. The health professionals who advised Julia were aware that her mother did not always seek advice for her promptly enough, but did not explicitly challenge her. The consequence of this was that professionals lost sight of the fact that, because of the non-engagement of mother, Julia did not receive the services she needed. Working with chronic non-compliance with services is difficult. **This is discussed in Finding 4 and 5.**



Professional recognition of adolescent neglect

2.7 The lack of engagement by Julia's mother to services designed to promote the wellbeing of Julia and her siblings should have been recognised as an indicator of adolescent neglect. There was evidence that Julia was not sufficiently supported to attend school, and there were times when she said she did not have bus fare because her mother had spent it. This had an impact on her ability to make use of the additional support she was provided with as a child with additional needs, and she was not able to attend counselling support provided at school because of her many absences. When Julia told school that she had been raped they appropriately suggested that her mother take her to see a health professional, which her mother delayed. Julia was not taken for her police interview (Achieving Best Evidence) on a number of occasions, and when a sexually transmitted infection was diagnosed she was not taken for her follow up appointment.

2.8 There were periods when the household she lived in was described as "chaotic" with the siblings being in conflict. This was of concern to the Accident and Emergency Department of the hospital who saw Julia's sister with an accidental injury in May 2011, and when the Coram parenting worker visited in September 2011 she was concerned about the level of conflict at the house and the behaviour of all of the siblings.

2.9 Although most professionals recognised that Julia was a young person who had disclosed a number of rapes, had a difficult family history and at times poor quality parental care, the lack of engagement and resistance by her mother meant that they were not able to form a relationship with her. There was an urgent need for a multi-agency meeting or an assessment to analyse her needs and her mother's response in the context of potential adolescent neglect – neither of which happened. **This is discussed in Finding 6**.

Uneven balance between "troublesome" rather than "troubled" Adolescence

2.10 A focus on Julia being "troublesome" was instigated by her mother and was not sufficiently challenged by professionals. Mother sought help from the GP and asked for Julia to be assessed by a Psychiatrist. A referral was made to Child and Family Consultation Service (one of the services of CAMHS) for Oppositional Defiance Disorder without an analysis of her very real difficulties or contact with any other professional. At school she was often difficult and badly behaved, and these concerns were a strong feature of her Statement of Special Educational Needs reviews'. The school did offer her counselling support, but poor attendance meant that these sessions were rarely attended.

2.11 The focus shifted to Julia as the problem, and this overshadowed the difficulties she was experiencing as young person with additional needs because of her mild learning disability and who had experienced a number of traumatic experiences. This was apparent after the incident when she threw boiling water over her sister. This was a serious incident and needed to be treated as such, but there is no evidence that once the criminal issues had been addressed, that her behaviour was analysed or linked to her recent disclosures of rape and sexual assault. The fact that she could be held responsible for her behaviour, yet none of her disclosures of rape had led to any prosecutions, despite significant and appropriate enquiries being made, was not acknowledged. Julia clearly needed help to make sense of this. There should have been a multi-agency plan to bring these two aspects together – the complex circumstances which were likely to have led to Julia feeling angry and the behaviour that appears to be the consequence. There was a need for a more holistic response. **This is discussed in Finding 3 and Finding 5.**

Lack of assessment

2.12 An Assessment for Julia was carried out nine months before the period under review in January 2010 as a result of a disclosure of sexual assault when she was aged 12. She was next assessed in October as a result of the referral made by the police regarding a disclosure of sexual assault, a gap of two and a half years. In this time there was one further disclosure of sexual assault and there

were concerns expressed about Julia's under age sexual activity. There were also concerns about family chaos and two specific incidents which led to two Assessments, both focussed on Julia's sister rather than Julia. These were comprehensive pieces of work, which gave a good sense of history but which focussed in their analysis on the presenting incident, and did not fully consider Julia and the concerns about sexual assault.

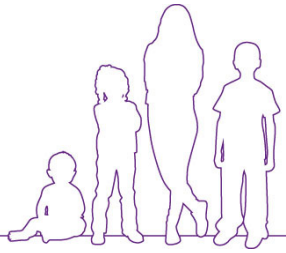
2.13 This lack of Assessment was influenced by existing processes for assessing the primary referred child rather than the whole family, and this is discussed in Finding 3. This meant that the proposals for interventions, made at various points were not connected to a clear understanding or analysis of Julia's needs and circumstances, and success, was unlikely. This is discussed in **Additional Learning.**

Multi-agency meetings and planning processes

2.14 It is striking that in the period under review there was only one multi-agency meeting with regard to Julia and this was held at the very end of the review period in January 2013. It would have been expected that some multi-agency meetings would have taken place given the lack of progress of any of the proposed services offered to Julia and her family. It is easy to place this responsibility entirely onto Children's Social Care, and although they had key worker responsibility, any other agency could have requested or called a multi-agency meeting, although all agencies do not seem to have felt enabled to do so. **This is discussed further in Finding 3 and Finding 6.**

Child in Need Processes

2.15 Julia was considered to be a Child in Need from July 2010 to January 2012 without there being a Child in Need Assessment, Child in Need meeting or Child in Need review. Despite concerns that this case should have been escalated to Child Protection, the Child in Need processes could have developed an effective multi-agency plan. This did not happen. Overall there was reasonable multi-agency information exchange across the period of this review but it was not focussed or part of a clear plan of action. This was particularly noticeable with regard to the school, who were managing concerns about Julia's non-



attendance, behavioural and emotional difficulties, her disclosures about sexual assaults and her special educational needs, without a clear overarching plan. Coram were asked to provide parenting support and provided this, but without it being clear how this fitted into an overall plan for this family. It is clear that the GP surgery was not included in the information exchange and did not also engage with any of the professionals involved with Julia.

2.16 The lack of any multi-agency meetings meant that there was no opportunity to establish goals, set the expectations for Julia's mother and the rest of the family, and review progress. The review would have been an opportunity to reflect on the lack of progress being made and to consider next steps or a change in direction. A face to face meeting in this context might have enabled all professionals to challenge the status quo, but the multi-agency team could also have been a virtual one if there had been a clear plan of action. At no point was information held by all shared in one forum, and so it is not surprising that the response was fragmented. **This is discussed in Findings 3 and 6.**

Effective safeguarding referrals from the multi-agency network

2.17 There were a number of occasions when the school, hospital, GUM[vi] and SARC[vii] and the police made prompt and clear referrals to Children's Social Care about Julia and her sister, and these were responded to quickly. In October 2010 school contacted Children's Social Care to inform them of a disclosure of sexual abuse by Julia. The hospital saw Julia's sibling, Courtney, on two occasions (May 2011 and September 2011) and on both they were concerned about the care provided to all the girls, and on the second occasion mother's discussion of Julia's underage sexual activity. These same concerns prompted GUM and SARC to refer in December 2012. The police made a referral in October 2012 when concerns about sexual assault regarding Julia came to their attention. This was all effective multi-agency practice, but the fact that it did not lead to a multi-agency response **is discussed in Finding 6.**

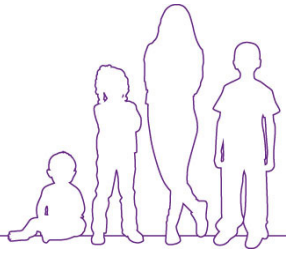
[vi] Genito-Urinary Medicine Clinic
[vii] Sexual Assault Referral Centre

Difficulties in escalating to Child Protection

2.18 Given the seriousness of the concerns regarding the disclosure of sexual assault by Julia from the ages of 12 – 14 years and her mother's attitude, it would have been expected that Child Protection procedures would have been considered. Julia made four disclosures of rape in a two year period. Rape of a child is sexual abuse, yet somehow this was not recognised. The police undertook extensive criminal enquiries to establish the facts of each case and to seek a prosecution of the perpetrators identified by Julia. The lack of a criminal prosecution should not have meant that there was no Assessment of significant harm and a decision made about whether a Child Protection response under Sec 47 of the Children Act 1989 was required.

2.19 When Julia made a disclosure of rape at the age of 12 in October 2010 there should have been a Strategy Discussion/meeting, as this was clearly an allegation of statutory rape. The Social Worker sought a Strategy Meeting but was hampered by delays in being able to contact the police. The Social Worker pursued this but ultimately it never took place. This appears to have been influenced by the fact that by the time the police officer and Social Worker were able to visit the family home and see Julia (some eight week after the incident) the police could take no further action because they did not have enough evidence to pursue a criminal investigation. As a result there was no Child Protection enquiry and Julia was seen as a Child in Need – not a child in need of protection. There were a number of professionals involved at this point, police, Social Worker, school, GP and School Nurse. All were aware of the seriousness of this incident, but because of the lack of any multi-agency meetings there was no forum to question why the case continued to be held at a Child in Need level. **This is discussed in Finding 7.**

2.20 A Child Protection response should have been considered when Julia threw boiling water over her sister. At this time the hospital raised concerns that Julia's mother had told them that Julia had been sexually active from an early age and there had been recent concerns about sexual abuse. The social work team thought there should have been a Strategy Meeting and Child Protection Case Conference, and sought advice from the Safeguarding Team. They received a



reply asking for clarification of the engagement of other teams, and there was no further recorded response.

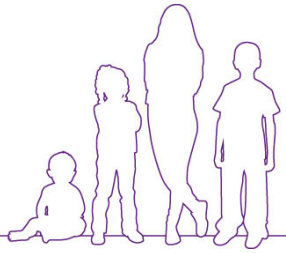
2.21 Julia made a disclosure of rape in October 2012 and this should have warranted a Child Protection response, but was held again at a Child in Need level and a Core Assessment started. A new disclosure of rape was made by Julia five weeks later and it was agreed that a Child Protection enquiry should be initiated and a Child Protection Conference convened. This did not happen. This final disclosure was incorporated into the Core Assessment started in November, and the conclusion was that Julia should once again be held at Child in Need level rather than being escalated to Child Protection, this was subsequently challenged by the social work team and an Initial Child Protection Conference held.

2.22 Over the period of the review the Case Group told the Review Team that adolescents were less likely to be subject of Child Protection processes and the social work team found this frustrating. This has changed over time, and there is now better recognition of the importance of Child Protection processes for this age group. This is discussed in **Additional Learning in section 4.**

The response to disclosures of sexual abuse and rape

2.23 The sexual assault and rape of a 12 year old child is a serious issue. Julia made four disclosures of rape over a three year period from when she was just 12 to 15 years old. It was particular striking how the language used about Julia by her mother such as Julia “had 15- 20 partners”, and the language used by Julia herself such as “she had consented to sex” was recorded across professional records without any clear critique or analysis about what it meant for Julia and her well-being. This language needed to be challenged, and addressed, not recorded without comment. The danger of the lack of challenge and analysis is that it can appear that professionals agree with the negative ideas behind the language used, which in this case they did not, but this needed articulating in the records. **This is discussed in Finding 2.**

2.24 There also needed to be a clearer connection made between the sexual health advice Julia received from a number of professionals and the sexual abuse she



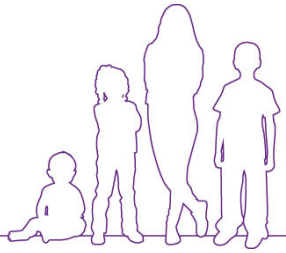
was experiencing. No one agency connected these two issues together so they were considered in isolation of one another. The lack of an assessment or multi-agency meeting meant there was no forum in which this could be discussed.

2.25 The police worked hard to achieve a prosecution. Given Julia's learning difficulties and her difficult early childhood experiences, it was always going to be complex for Julia to provide a clear picture of what had actually taken place, and this was indeed so. The difficulties in achieving a criminal prosecution influenced the practice response at times. When Julia made a disclosure in October 2010, the difficulties of achieving a criminal prosecution led to the belief that a Strategy Meeting was no longer required. This was incorrect. There appears to have been confusion regarding the criminal response, carried out by the police, and the civil response, carried out by the multi-agency team in the context of a disclosure of sexual abuse and Child Protection processes.

2.26 There is now greater multi-agency awareness and response to the sexual exploitation of young people locally (see the section on learning from the fringes page) and nationally. However, over the period of the review Julia was not always understood to be a victim of sexual exploitation by professionals, her parent/siblings and significantly she also did not understand that this was what was happening to her.

2.27 This review highlights the importance of good quality multi-agency working and a shared multi-agency awareness of the importance of and responsibility for ensuring:

- effective holistic assessments
- effective Child Protection and Child in Need processes
- analytical information sharing and particularly the sharing and appraisal of assessments and decision making
- good quality planning and reviews
- an understanding of adolescent neglect,
- an appropriate balance between sexual health advice and sexual abuse/exploitation.



These are all essential elements of an effective response to child sexual exploitation and were often absent for Julia. The challenge for the Board is to reflect on the Findings that follow and to consider how the practice gaps identified in this case can be addressed to ensure that sexual exploitation of young people is effectively responded to in the future.

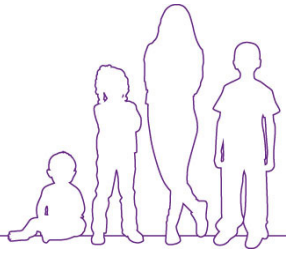
3 THE FINDINGS

Analytic process for establishing systems findings

3.1 The aim of a Learning Together case review is to use a single case as a 'window on the system', to uncover more general strengths and weaknesses in the Child Protection system. A four-stage process of analysis is used to articulate how features of the case can lead to more general systems learning. The first is to look at how the issue manifested in the case specifics, this will often be presented as one example, even if there are several such examples. This evidence comes from the analysis of the reconstruction of the unfolding case, documentation and an examination of the key practice episodes.

3.2 The second step is to consider whether the issue observed in this case is 'underlying'. That is, that it is not a 'quirk' of the case, but is likely to represent practice in other cases and by other practitioners. The third step is to consider how geographically widespread and numerically prevalent the issue is within the system. Sometimes it is not possible within the scope of a review to collect this data. The sources for these steps will be information from the Review Team and Case Group, any performance data, national research and other reviews in a variety of combinations. In this review, it has not been possible to obtain some of the data requested to populate these steps – this has been highlighted where relevant.

3.3 The last step is to articulate why this issue matters, what are the risks to the safeguarding system. Based on this finding, questions and considerations for the LSCB are formulated.



Categories of underlying patterns

3.4 The systems model that SCIE has developed includes six broad categories of underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change. Not all the typologies will have a finding associated with them but they are designed to allow for structured enquiry as to what the data has revealed:

- Human biases (cognitive and emotional):

Are there common errors of human reasoning and judgement that are not being picked up through current case management processes?

- Family-professional interaction:

What patterns are discernible in the ways that professionals are interacting with different family members, and how do they help and or hinder good quality work?

- Communication & collaboration in responses to incidents:

Are there particular good or bad aspects to the patterns of how professionals respond to specific incidents (e.g. allegations of abuse)?

- Communication and collaboration in longer term work:

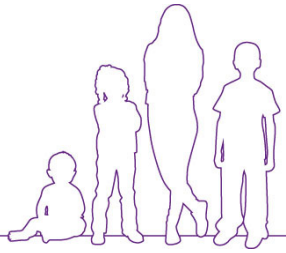
Were any good or bad patterns identified about ways of working over a longer period with children and families?

- Tools:

What has been learnt about the tools and their use by professionals?

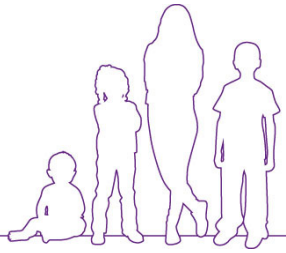
- Management system:

Are any elements of management systems a routine cause for concern in any particular ways?

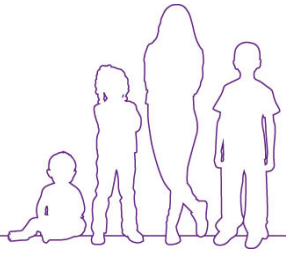


3.5 This review has prioritised seven findings for the Board to consider:

Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual abuse/exploitation	Communication and collaboration in longer term work
Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection.	Communication and collaboration in longer term work
Finding 3: Is there a pattern whereby the Child in Need procedures are not routinely being used leaving children and young people without formal plans and review?	Communication and collaboration in longer term work
Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response.	Family-professional interaction:
Finding 5: Is there is a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm.	Communication and collaboration in longer term work
Finding 6: Is there a pattern whereby Multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?	Communication and collaboration in longer term work



Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by others or themselves as an integral part of the safeguarding network?	Communication and collaboration in longer term work
Additional Learning	
1. The importance of holistic assessments 2. Difficulties in escalating to Concerns about Adolescents to Child Protection	



Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual abuse/exploitation

Why does it matter?

3.6 Nationally there is a clear legal framework with regard to sexual activity regarding children and young people. Children aged less than 13 years are not legally capable of consenting to sexual activity and sexual activity with a young person under the age of 16 is a criminal offence. However, there is some evidence that increasing numbers of young people under the age of 16 are engaging in sexually activity. Guidance from the Crown Prosecution Service states that young people who are of a similar age should not be prosecuted or issued with a reprimand or final warning where sexual activity was mutually agreed and non-exploitative. The law makes clear that children under 13 are particularly vulnerable, so to protect younger children any sexual activity with a child aged 12 or under will be subject to the maximum penalties – whatever the age of the perpetrator.

3.7 It is the task of all professionals to evaluate these early sexual experiences to assess whether they are sexually exploitative. This was raised by the Bichard Inquiry (2003)[viii] into the Soham murders which highlighted the importance of taking a critical approach to young people's early sexual experiences and for professionals to be aware of the potential for exploitation. To support this approach a checklist was introduced into Working Together 2006[ix] and this has formed the basis for all current sexual exploitation frameworks.

3.8 Sexual exploitation has become an important policy objective, and one that is recognised as having been difficult for all professional groups to respond effectively:

[viii] Cabinet Office (2004) The Bichard Inquiry London: The Stationery Office
[ix] HM Government (2006) Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children, London: The Stationery Office

"The lack of curiosity about child sexual exploitation shown by all official agencies has been a running theme… professionals did not recognise the existence of the exploitation, were not aware of the scale of the abuse and were not sharing information, this was partly due to assumptions that victims were engaging in consensual relationships and the inability to engage with them.' Beckett, H et al (2013[x])

3.9 Professionals must ensure that young people are not being sexually exploited and have made an informed choice/consented to sexual activity. The issue of consent is important here and is described in Section 74 of the Sexual Offences Act 2003 as:

'if (s)he agrees by choice, and has the freedom and capacity to make that choice'.

3.10 Professionals should consider this in two stages. Whether a young person has the capacity (i.e. the age and understanding) to make a choice about whether or not to take part in the sexual activity at the time in question and whether he or she was in a position to make that choice freely, and was not constrained in any way.

3.11 At the same time professionals are also required to give young people advice and support about sexual relationships, contraception and sexual and reproductive health including pregnancy and abortion.

3.12 The Labour Government developed its Teenage Pregnancy Strategy (Social Exclusion Unit, 1999[xi]) with the aim of reducing teenage pregnancy rates by 50%. In the period between 1998 and 2011 the under 18 conception rate fell by 34% (Office for National Statistics, 2013). Teenage pregnancy and sexual health continue to be prioritised in the policies of the Coalition Government. The Public Health Outcomes Framework 2013-16 (Department of Health, 2011[xii]), against which national and local government will monitor improvements in public health,

[x] Office of the Children Commissioner (2013) *If only someone had listened – the final report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG)*
[xi] Social Exclusion Unit (1999) Teenage Pregnancy Report, London: Social Exclusion Unit.
[xii] Department of Health (2011) Health Survey for England, London: DH

includes reducing under-18 conception rates and late diagnosis of HIV, and increasing Chlamydia diagnoses among 15-24 year-olds as key sexual health indicators. Alongside this, the Framework for Sexual Health Improvement in England[xiii] highlights reducing rates of under 18 conceptions and STIs as two of the five priority areas for improvement (DH, 2013).

3.13 Although this policy guidance now makes clear that all professionals providing sexual health advice must be aware of child protection and safeguarding issues as well as having guidelines and referral pathways in place for risk assessment and management of child sexual abuse, there remains a potential contradiction between the responsibility to address sexual exploitation and promote positive sexual health.

How did it manifest in this case?

3.14 Julia's mother sought advice from the GP when she disclosed that Julia had been raped six weeks before her 13th birthday. This led to contraceptive advice, and there is no evidence that she was assessed to see whether her experiences had been abusive in line with existing policies and procedures and there was no referral to Children's Social Care. The focus was on sexual health advice rather than safeguarding.

3.15 In November 2011 when Julia was 13 she sought advice about sexual relationships from the School Nurse who assessed her as Gillick competent under the Fraser guidelines, and she was provided with condoms. This was in line with existing procedures regarding sexual health support. The School Nurse was not aware of the other concerns regarding Julia's sexual activity, and there was no opportunity or forum for her to contextualise the support for sexual health alongside all the other concerns about this vulnerable young person.

[xiii] Department of health (2013) A Framework for Sexual Health Improvement in England: https://www.gov.uk/government/uploads/system/uploads/attachment data/file/142592/9287-2900714-TSO-sexualhealthpolicyNW accessible.pdf

3.16 The Child in Need Plan developed as a result of the Core Assessment undertaken in July 2010 and which remained unchanged over a period of two and a half years, focussed on sexual health advice and parenting support.

How do you know it is underlying?

3.17 There were numerous occasions on which Julia made allegations and sought sexual health advice, and on each occasion there was a stronger professional focus on advice-giving rather than exploring issues of consent and abuse. It was at the end of the review period that concerns about sexual exploitation were voiced, and this was after four disclosures of rape and numerous allegations of underage sexual activity. The consistency of practice suggests strongly that this was an underlying tension inherent within the different role that professionals play.

How prevalent is the issue?

3.18 No specific work was done by the Review Team to understand the prevalence of this issue in Thurrock, although the Case Group and Review Team both recognised that the imbalance was present in many of the polices regarding early sexual experiences. The extent of sexual exploitation is not well understood nationally, both because of the inconsistencies in data collection and because many young people do not recognise that they are being exploited. When talking about the scale of child sexual exploitation, Sue Berelowitz, the Children's Commissioner told the Home Affairs Select committee[xiv] convened to look at this important issue that "*there is not a town, village or hamlet in which children are not being sexually exploited*." The committee concluded that "*it is obvious that child sexual exploitation is a large-scale, nationwide problem and evidence to the Committee indicates that it is increasing"*. At the same time increasing numbers of young people under the age of 16 are engaging in sexual behaviour under the age of consent.

[xiv] House of Commons :Home Affairs Committee (2014) Child sexual exploitation and the response to localised grooming Second Report of Session 2013–14 : http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/68i.pdf

Finding 1

The principal finding of "*If only someone had listened" – the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG*)[xv] was that despite increased awareness and a heightened state of alert regarding child sexual exploitation children are still slipping through the net and falling prey to sexual exploitation. Research published by Barnardos[xvi]and the evidence provided to the Home Affairs Select Committee[xvii] suggest that gaps remain in the knowledge, practice and services required to tackle this problem. Part of an effective response will be to ensure that there is a professional balance between appropriate advice regarding sexual health and a heightened awareness that this might be an opportunity to consider the potential for sexual exploitation.

Questions for the Board

Does the Board recognise that this is an issue within Thurrock?

Does this Board have any further information about what is getting in the way of enabling professionals to strike a balance between advice around sexual health and an awareness of sexual exploitation?

What are the options available for tackling this issue?

What action would the Board need to take to ensure that they know this has been addressed?

[xv] Office of the Children Commissioner (2013) If only someone had listened" – the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG)
[xvi] Barnado's (2012) Cutting them free: how is the UK progressing in protecting its children from sexual exploitation? London: Barnado's.
[xvii] House of Commons: Home Affairs Committee (2014) Child sexual exploitation and the response to localised grooming second report of session 2013-14: https://www.publications.parliment.uk/pa/cm201314/cmselect/cmhaff/68/68i.pdf

Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection

Why does it matter?

3.19 Finding 1 made clear the legal framework regarding underage sexual activity and the contradiction in policy which makes underage sexual relationships illegal, whilst at the same time recognising the need for support when it takes place in the context of choice and consent. This was not the case for Julia. She made disclosures of rape on four occasions, when she was 12, 13 and 14. This was her language and reflected her experiences. Professionals should have considered what this meant and been clear about making a professional analysis of what had happened, in order to address it effectively. It would have been more accurate for those agencies outside of the criminal justice system to record that Julia had been sexually abused. Sexual abuse is described in the SET[xviii] (Southend, Essex and Thurrock) procedures as

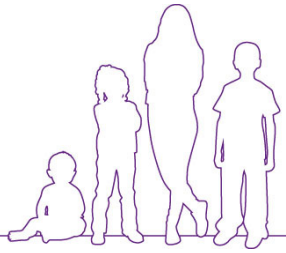
> "*forcing or enticing a child/young person to take part in sexual activities, ...whether or not the child is aware of what is happening*"

3.20 There is growing recognition that child sexual exploitation (CSE) is a form of sexual abuse "*that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things ... and where the abusive relationship between victim and perpetrator involves an imbalance of power which limits the victim's options"*.

3.21 It is a form of abuse which is often misunderstood by victims and outsiders as consensual. (Barnardo's 2012[xix]). This makes it complex because of the power

[xviii] https://www.thurrock.gov.uk/how-we-keep-children-safe/set-child-protection-procedures

[xix] Barnardo's (2012) Cutting them free: how is the UK progressing in protecting its children from sexual exploitation? London: Barnardo's.



dynamics of perpetrators and that young people themselves do not recognise that they are being abused or exploited.

How did it manifest in this case?

3.22 Julia was described by a number of professionals as making "allegations" of rape – this is a phrase more suited to adults where there are legal issues regarding proof. For young people there is a need to consider whether what they are talking about is sexual abuse - which would now need to be seen in the context of sexual exploitation. There is a still a burden of truth here – but one which needs to be seen in the context of significant harm as outlined in the Children's Act 1989 and enshrined in subsequent versions of Working Together. For young people under the age of 13, and for those with a learning difficulty in the older age range, professionals need to be focussed on the harm experienced, as well what actually happened. For Julia, professionals wrongly emphasised ascertaining the 'truth' of the 'allegations' – rather than focusing on what was the harm to her.

3.23 It was recorded that Julia told professionals that she "consented" to sexual activity without there being sufficient analysis or reflection of this statement. She needed professionals to help her understand that it is not uncommon for young people to be confused about this. A recent report, undertaken as part of the Children's Commissioners' review of sexual exploitation, highlighted the extent to which young people are confused about consent[xx]. Julie needed professionals to help her see what had happened to her was not actually consensual, and help her have an accurate understanding of issues of choice and accountability. This was pertinent when she was below the age of 13 and unable to legal consent, but also when she was 14 and 15.

3.24 A number of records across the multi-agency network recorded that Julia's mother had told them that she had "15 - 20 partners" from the age of 12. This word was used without analysis or challenge, and the implications for Julia's

[xx] Coy, M., Kelly, L., Elvines, F., Garner, M. and Kanyeredzi, A. (2013). "Sex without consent, I suppose that is rape": How young people in England understand sexual consent. London: Office of the Children's Commissioner.

well-being were not explored. The use of this word had the potential to make her experiences of sexual exploitation hidden.

3.25 There was some professional confusion about the difference between "risky behaviour" and risk factors. In professionals records Julia was described as engaging in "risky behaviours" something her mother mentioned to all professionals she was in contact with. This phrase was used inaccurately and implies (without professionals actually intending to do so) that Julia might be responsible for what happened to her because of her own behaviour. This needed a clearer analysis and for professionals to distinguish between "risky behaviours" which are part of some adolescent's behaviour and "risk factors" which were those aspects of her life that made normal risk taking more dangerous.

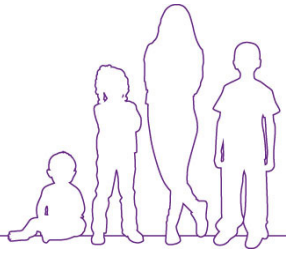
How do you know it is underlying?

3.26 The Review Team and Case Group told us that it was common practice across all agencies to record what children and young people told them uncritically, in the context of early sexual experiences. They considered that professionals understood the importance of recording what young people told them as a way of being child centred.

How prevalent is the issue?

3.27 Although there are no national or local figures regarding the number of young people who are being sexually exploited, research suggest that a significant number of young people are affected by this issue. The complex issue of language and its use in the context of exploitation was something that the Case Group and Review Team recognised affects all professionals. Nationally, the Children's Commissioners Office inquiry[xxi] into sexual exploitation expressed concern about the language used by professionals which led to victims being

[xxi] Office of the Children Commissioner (2013) *If only someone had listened" – the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG*)



blamed for the exploitation with the consequence that they were not effectively safeguarded.

Finding 2

Sexual exploitation is a serious issue and one that has a profoundly negative effect on young people's lives and their wellbeing. It is essential that all professionals feel able to recognise young people who are being sexually exploited and that they are able to respond effectively. This response must be child centred and all professionals must take a critical approach to the use of language in this complex area of practice, so that risks are recognised and young people are not held responsible for the harm perpetrated by others.

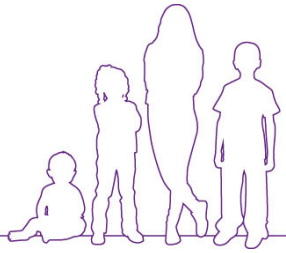
Questions for the Board

Do the Board recognise that this is an issue that it should be concerned about?

How can the Board ensure that this issue is addressed within its Child Sexual Exploitation strategy?

Are there other opportunities or lever's at the Boards disposal for changing professional practice and language in this area?

How will the Board know if it is being effective in addressing this issue of language?



Finding 3: Is there a pattern whereby the Child in Need procedures are not routinely being used leaving children and young people without formal plans and review?

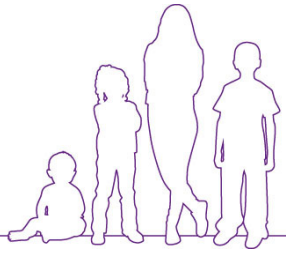
Why does it matter?

3.28 The Child in Need processes outlined within the Children Act 1989 further reinforced by the Assessment Framework Guidance 2000 and Working Together 2010[xxii] were instigated to ensure that children and young people who were not subject to safeguarding plans received a carefully planned approach to their needs, which was reviewed over time. The SET procedures for Thurrock make clear that:

"*An initial Child in Need plan is used to support the provision of services by Children's Social Care. The role of other relevant agencies should be considered within this initial plan and their involvement discussed and agreed with them, using a multi-agency meeting to formulate the plan, including parents. The initial plan must be reviewed within three months and thereafter monitored and reviewed at regular intervals, not less than once every six months*. (Section 8.2 SET Procedures)

3.29 The Child in Need plan is an essential next stage after an Assessment has taken place. The purpose is to set a plan of action, based on the assessed need. This makes clear to young people how the Local Authority plans to support them and ensures that parent's/carers know what is required of them to promote their children's outcomes. It also creates the framework for multi-agency work. The ultimate aim is to improve children's outcomes and so the review mechanism is an essential part of the process. This enables progress to be marked, and services provision to be amended if necessary. This process should activate multi-agency support for an agreed plan, and should not be dependent on a pre-existing network.

[xxii] Department for Children, Schools and Families (2010) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. March 2010



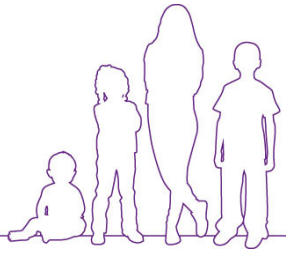
3.30 During this review the Review Team were told by members of the Case Group that Child in Need meetings do not always take place when there are no other agencies involved with the child or young person, meaning that there appears no point in having a meeting. In Julia's case there were times when other agencies were involved and particularly school – who were in fact a cluster of different professionals with differing responsibilities to Julia. This highlights fundamental misunderstanding of the process and the importance of planning for children and young people.

How did it manifest in this case?

3.31 Julia was held from July 2010 to January 2012 as a Child in Need case. During this time there was no new plan made, no Child in Need meeting or review. The services proposed were not engaged with by Julia or her mother in any meaningful way. There was no opportunity for the professionals involved with the family to consider all the information they held about Julia and to consider whether the approach to her needs was working. The Case Group informed the Review Team that the reason there was no Child in Need meetings was because there was not 'multi-agency involvement' in addition to Social Care. However, there was at least two other key agencies involved throughout the review period. The school, for example, was providing counselling support, behavioural support, putting in place a plan for Julia's special educational needs, attempting to address her poor attendance and providing sexual health advice. She was also receiving contraceptive advice from her GP who also acted upon concerns regarding her behaviour expressed by Julia's mother. This work happened in isolation.

3.32 If there had been a plan which was reviewed, the many crises that occurred over the period of the review and the lack of engagement of Julia's mother would have amply demonstrated that the approach being taken was not working, and the analysis of her needs inaccurate.

3.33 No professional involved with Julia and her family asked about the absence of Child in Need meetings or a review of the plan which was made six months before this review started.



How do you know it is underlying?

3.34 It has not been possible to establish how common it is for Child in Need processes not be used in the Adolescent Team or other teams in Thurrock. The Case Group members told us that pressures during the period under review led to difficulties in maintaining Child in Need planning and review processes. The fact that no agency involved with Julia asked about why a Child in Need meeting and review was not taking place suggests that Child in Need processes is not firmly established in the multi-agency network. Additionally, there was a belief that the absence of an established multi-agency network meant that Child in Need processes would not be helpful. Statistics are not collected nationally about Child in Need meetings or plans, as the focus is on Child Protection processes. Evidence from Serious Case Reviews suggests that Child in Need processes are not always prioritised.

How prevalent is the issue?

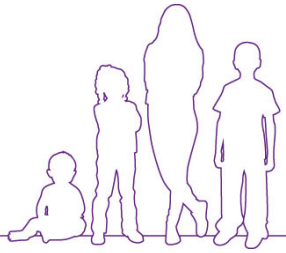
3.35 It has not been possible to establish how prevalent this is as an issue. This is covered by the questions for the LSCB below.

Finding 3

Effective processes to support children, young people and their families are essential. The Child in Need processes are intended to build on good quality assessments, by developing a plan of action , which is owned and developed by the multi-agency group, and is reviewed regularly to see what progress is being made to promote children and young people's outcomes. If these processes are not used, interventions are unlikely to be clearly focussed on children's needs and are unlikely to provide effective help and support.

Questions for the Board

Are the Board aware that Child in Need processes are vulnerable to pressures on Social Work teams, and of a potential misunderstanding of when Child in Need meetings should be convened?



Is there more the Board could do to establish the extent of this issue, e.g. case audit?

What can the Board do to address this?

How will the Board know they have been successful in ensuring that Child in Need processes is embedded in multi-agency practice?

Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response

Why does it matter?

3.36 Local Authority Children Services, other Local Authority departments such as Education and Health Authorities have a duty to safeguard and promote the welfare of children in their area who are in need and to promote the upbringing of such children, wherever possible by their families, through providing an appropriate range of services. In carrying out this responsibility the "client" or primary "service user" is the child or young person. In the Munro review[xxiii] of the safeguarding system, it was re-emphasised that children and young people should be at the heart of the provision of services. The vision of the Convention on the Rights of the Child[xxiv] and the Children Act 1989 is that they are individuals, members of a family and a community, with rights and responsibilities appropriate to their age and stage of development. They are not "the property of their parents" a point made by Baroness Butler-Sloss: '*the child is a person not an object of concern*[xxv].

3.37 There is considerable evidence from research and serious case reviews that children and young people can become invisible to services because of the

[xxiii] Munro, E. (2011) The Munro review of child protection: final report: A child centred system. London TSO
[xxiv] The United Nations, (1989), The United Nations Convention on the Rights of the Child (available online at https://www.2ohchr.org/english/law/crc.htm)
[xxv] Cm 412, (1998), Report of the Inquiry into Child Abuse in Cleveland 1987, London, HMSO.

needs of their parents or caregivers, and this is apparent when those parents choose not to engage with services targeted at improving the outcomes and wellbeing of their children.

3.38 Recent research by Eileen Munro[xxvi] suggests that "Did Not Attend" should be reconceptualised as 'Was Not Brought' – i.e. failure to attend/engage with appointments should be an indicator of neglect.

How did it manifest in this case?

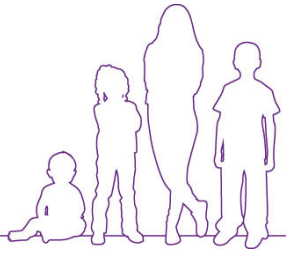
3.39 There was a long history of non-engagement by Julia's mother throughout the period under review. Julia's mother only responded to contact from services in times of crisis. She was not at home for appointments and home visits organised by the Social Workers, she did not return telephone calls or respond to letters. She failed to follow up on the referral to the Sexual Health Advisor and did not follow through on a number of referrals for parenting support and did not attend planned school appointments regarding concerns about attendance and behaviour. Paradoxically, the lack of engagement, suggestive of a poor level of care for Julia, resulted in Julia receiving less rather than more support from services.

3.40 The Social Workers considered seeing Julia at school, and one appointment was made. A decision was made that because the case was held at a Child in Need level it was not possible to see her without the consent of her mother. The lack of engagement by mother meant that consent could not be sought. Consent is of course important and respecting family life appropriate, but this approach served to allow mother's non engagement to restrict access to a Social Worker for Julia.

3.41 This had clear consequences for the wellbeing of Julia:

- She was not able to form a relationship with her Social Worker - which is essential if effective work is to be done about sexual abuse and sexual exploitation
- Her emotional, educational and physical needs were neglected.

[xxvi] Munro, E (2012) *Review: Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for practice.* Journal of research in nursing, 17(2). Pp. 193-194.



How do you know it is underlying?

3.42 The Case Group told us that working with parental non engagement, particularly in the context of adolescence, was a regular occurrence and a great frustration. The Biennial Review of Serious Case Reviews[xxvii] highlighted the extent of parental resistance and its negative impact on improving children's outcomes.

How widespread is the pattern?

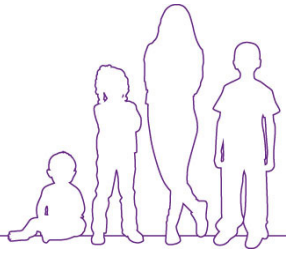
3.43 There is little information available nationally or locally about the extent of non-engagement in work with families at Child in Need level. Research and serious case reviews suggest that nationally this is a significant issue, which has a profound impact on children and young people's outcomes.

How prevalent is the issue?

3.44 Whilst this review has not established how prevalent this issue is, Ferguson (2010[xxviii]) suggests: "*We have failed to acknowledge the sheer scale of resistance and hostility that professionals have to bear*"**.**

[xxvii] Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., and Megson, M. (2012) New learning from serious case reviews: a two year report for 2009-2011. London: HMSO

[xxviii] Ferguson. H (2010) Walks, Home Visits and Atmospheres: Risk and the Everyday Practices and Mobilities of Social Work and Child Protection. British Journal of Social Work



Finding 4
The non-engagement of parents in services aimed at promoting the well-being of their children/young people is a significant issue. It has an impact on young people's well-being and their outcomes, and causes more pressures on over stretched professionals. It is also costly for services. A lack of recognition of this as a safeguarding issue means that children and young people are not always effectively protected.

Questions for the Board

Are the Board aware of this as an issue facing professionals?

Does the LSCB know if staff locally has been equipped to work with resistant parents both in single agency and partnership working?

How might the LSCB help practitioners overcome this obstacle to effective practice?

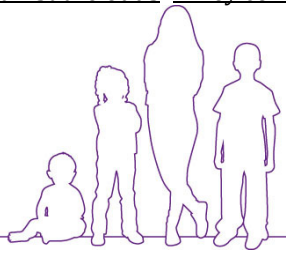
How will the Board know when this has been effective?

Finding 5: Is there a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm?

Why does it matter?

3.45 There is considerable evidence about the developmental world of adolescents (Coleman and Hagell 2007[xxix]). This stage of development characterised for some young people as engaging in risky behaviour such as drugs, alcohol and sexual experimentation. This sense that this is "normal" adolescent behaviour has caused some professional confusion about risk taking behaviour, which is part of adolescence as opposed to "risk factors" which make appropriate "risk taking behaviour" more dangerous. This has been recognised particularly in the context of sexual exploitation, where young people are perceived as engaging in risky behaviours and a causal link is made with sexual exploitation, inadvertently

[xxix] Coleman, J and Hagell, J. (2007) Adolescence, risk and resilience: Against the odds: Wiley.com



making those young people feel like it is their fault – that they are to blame. It is critical that we separate out these two issues and highlight the key issue of the risk factors such as adolescent neglect rather than focus solely on adolescent behaviour.

3.46 The recent House of Commons Inquiry into the operation of the Child Protection System in England and Wales[xxx] was presented with considerable evidence that young people aged 14- 18 are not receiving effective protection and support from the multi-agency safeguarding system. This Inquiry found that there was a lack of services to meet the particular needs of adolescents, a failure to look beyond behavioural difficulties, a lack of recognition of the abuse and neglect of teenagers and particularly the long term impact on them.

3.47 The neglect of children and young people is a national concern and is recognised as posing a significant threat to the wellbeing and outcomes of children and young people across the whole developmental spectrum, in the short and long term[xxxi]. Comprehensive help to children and young people has been hampered by professional concerns that it is often poverty and disadvantage which cause neglect and there has been reluctance by professionals to further discriminate against social excluded and disadvantaged communities[xxxii].

3.48 Recent research (Stein et al 2009[xxxiii]) has highlighted the significance of adolescent neglect, and its link to sexual exploitation, early pregnancy, anti-social behaviour, poor mental health and self-harm.

3.49 Despite this there remains concern about the recognition and response to adolescent neglect. This is in part due to differing professionals understanding

[xxx] House of Commons Education Committee (2013) Children first: the child protection system in England Fourth Report of Session 2012–13: children-first-the-child-protection-system-in-england.pdf
[xxxi] Gardner, R. (2008) Developing an effective response to neglect and emotional harm to children. London: NSPCC
[xxxii] Action for Children (2011) Neglecting the issue: impact, causes and responses to child neglect in the UK. London: Action for Children.
[xxxiii] Stein, M., Rees, G., Hicks, L. and Gorin, S. (2009) Neglected adolescents: literature review. London: Department for Children, Schools and Families (DCSF).

of what neglect is – and although there is national and local guidance regarding the neglect of children more generally, there is no definition of adolescent neglect.

3.50 The definition in the SET (Southend, Essex and Thurrock) procedures echoes that outlined in National Guidance – Working Together 2013 which provides a much broader framework for understanding neglect, but the issues for adolescents are not explicitly covered.

"Neglect involves the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health and development. Neglect ...may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *Ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment.*
- *The neglect of, or unresponsiveness to, a child's basic emotional needs.*

And Medical Neglect is failure to ensure access to appropriate medical care or treatment".

3.51 One of the difficulties facing professionals who assess adolescent neglect is that many of the outcomes associated with neglect are also associated with young people who are struggling to come to terms with this new stage in their development. This can lead to an underestimation of both the present experience of being neglected and the cumulative impact of past poor quality care. Professionals can come to sympathise with the parents/carers at having to deal with difficult behaviour, rather than recognising that neglectful care can lead to adolescent difficulties. There is some evidence from serious case reviews that in this way adolescents move for being seen as "troubled" to "troublesome" and the service response changes.

3.52 In addition, research suggests that professionals are less likely to feel justified in labelling a young person's experiences as neglectful if they recognise that the family circumstances are characterised by poverty and disadvantage, and if they

feel parents are not deliberately intending to cause children harm – but are struggling with their own issues[xxxiv]. This has led to many children and young people's circumstances not being sufficiently responded to – for adolescents this may mean that the difficulties they experience are seen as a function of who they are – rather than as a function of the care they receive. If professionals do not challenge the quality of care adolescents are provided with , the evidence suggest that they can turn in on themselves, and this can leads to poor self-worth and for some a sense of helplessness about who you can turn to for help. An effective response to adolescent neglect is therefore critical.

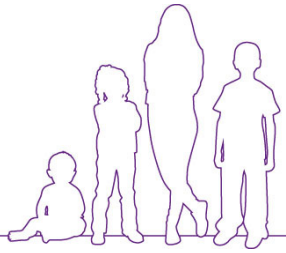
How did it manifest in this case?

3.53 There was considerable evidence that Julia had been neglected from her early years, and that this continued thought to adolescence.

3.54 In May 2011 the hospital made a referral to Children's Social Care because Julia's sister, Courtney, had come to the Accident and Emergency Department with suspected concussion after being hit on the head by a falling door at the family home. The hospital said that the injury was accidental, but the reason for the referral was a concern about all the siblings who had reported to hospital staff that there was chaos at home, that their mother took no interest in them and provided no practical or emotional support. The referral from the hospital was responded to with an Initial Assessment of the sibling who received the injury. This concluded that the incident had been accidental and the decision was case closure.

3.55 These concerns about neglect were well supported by the recent concerns that Julia's mother did not enable Julia to seek medical advice when she disclosed that she had been raped, and when a referral for Julia and her sister was made to the Sexual Health Advisor her mother did not enable them to attend and did not follow up on the advisors attempts to contact her. The school found it extremely difficult to make contact with her mother when they had concerns about Julia's behaviour and angry outbursts, and her mother only intermittently

[xxxiv] Action for Children (2011) Neglecting the issue: impact, causes and responses to child neglect in the UK. London: Action for Children.



attended appointments regarding special educational needs. This information was not assessed as part of a pattern of neglectful care.

3.56 Given this background, it was not surprising that Julia presented challenging and angry behaviour. Although it was appropriate that this was addressed, it also needed to be contextualised alongside the quality of care she received and her early sexually abusive experiences. The multi-agency balance for Julia moved to her being viewed as more troublesome than troubled.

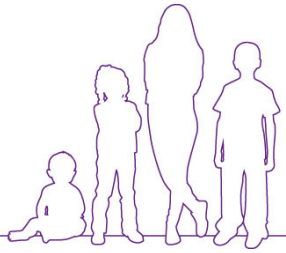
How do you know it is underlying?

3.57 The Case Group considered that adolescent neglect was a significant issue in their work. Research[xxxv] and the Ofsted analysis of serious case reviews[xxxvi] also suggest that adolescent neglect is a significant national issue.

How prevalent is the issue?

3.58 Overall the national evidence suggests that neglect is a significant category of maltreatment both during childhood and adolescence.
In Thurrock during 2012, 61% of children/young people were subject to Child Protection Plans because of neglect and 16% of all plans were regarding young people aged 12 years or older.

[xxxv] Stein, M., Rees, G., Hicks, L. and Gorin, S. (2009) Neglected adolescents: literature review. London: Department for Children, Schools and Families (DCSF).
[xxxvi] Ofsted (2011) Ages of concern: learning lessons from serious case reviews: http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews



Finding 5

Adolescent neglect is a significant issue which has a profound effect on young people's lives. Recognising and responding to adolescent neglect is a critical part of addressing sexual exploitation, and an ineffective response leaves young people at risk of significant harm.

Questions for the Board

Are the Board aware that adolescent neglect is a significant issue facing professionals?

How can this be tackled by the Board?

How can professionals be supported to develop a more effective response to adolescent neglect?

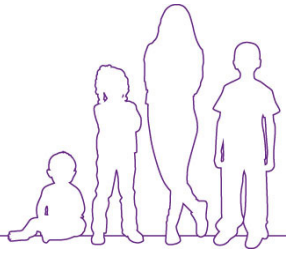
How will the Board know its response has been effective?

Finding 6: Is there a pattern whereby multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?

Why does it matter?

3.59 Good quality multi-agency working is essential to the effective safeguarding of children and young people. This has been a core finding of all the public Inquiries regarding serious child deaths (there have been 75 since 1945[xxxvii]) and most of the serious case reviews that are undertaken in England. Poor multi-agency working was a central criticism of practice in the Victoria Climbié Inquiry

[xxxvii] Winter, K (2011) Building Relationships and Communicating with Young Children: A Practical Guide for Social Workers: London: Routledge



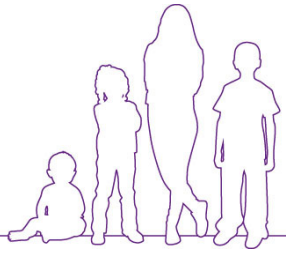
and was also highlighted by Munro in her review[xxxviii] of the child protection system. These reviews and inquiries make it clear that effective multi-agency working is about more than effective and timely information sharing, although this is obviously critically important.

3.60 Multi-agency working must be about being prepared to share with others your own professional understanding of a child/young person's needs and circumstances, contributing this analysis to the assessments being carried out by any agency. Research[xxxix] shows that many assessments of children/young people collate information, rather than analyse it. Part of the analytical process is enabling the multi-agency group to comment on the completed assessment or the analysis and conclusion in order to connect with a shared understanding of the needs of the child/young person and to understand their role in any future plan of work. Serious case reviews have suggested that this is not the case and that a belief system has developed which suggest that it is not permissible to share the assessment with other professionals without the permission of the parents. The Guidance issued as part of the Assessment Framework makes it clear that this is not the case.

3.61 Multi-agency working also means multi-agency planning for a child/young person. The research is clear, where there is careful multi-agency planning, the outcomes for children tend to be better and where planning is weak, there is more evidence of drift and poor outcomes.

3.62 Research also suggests[xl] the importance of the multi-agency network coming together to share their thinking and analysis in a face to face meeting. Although much of this work is done and can be done in a virtual way, it is necessary for professionals to meet to review progress, particularly where progress is not

[xxxviii] Munro, E. (2011) The Munro review of child protection: final report: A child centred system. London TSO.
[xxxix] Broadhurst, K et al (2010) Ten pitfalls and how to avoid them: What research tells us: NSPCC: http://www.nspcc.org.uk/Inform/publications/downloads/tenpitfalls_wdf48122.pdf
[xl] J Selwyn, E Farmer, D Turney, D Platt (2011): Improving Child and Family Assessments: Turning Research Into Practice: Jessica Kingsley Press



being made. Reder and Duncan (1998)[xli] have highlighted the complexity of communication across networks in safeguarding practice where all interaction is virtual. Meetings matter to the outcomes for children, young people and their families.

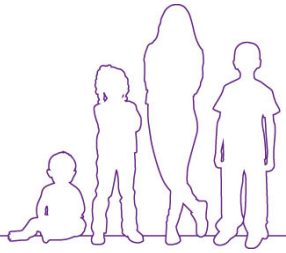
3.63 Multi agency work is also about appropriate professional challenge. Serious case reviews highlight how barriers to effective challenge across professionals group and hierarchies have a profound impact on safeguarding practice.

How did it manifest in this case?

3.64 There was evidence that all agencies (with the exception of the GP's who were not included and did not contribute – something discussed in Finding 8) communicated with each other and kept each other informed of what was happening for Julia and her mother. There was overall some good information sharing between the school and social work team. The school became a mini team of professionals (teacher, school liaison, School Nurse, Attendance Officer, Special Needs Coordinator) and their information was usually amalgamated and passed on to the social work team. The unintended consequence of this approach was that the School Nurse appears to have been unaware that Julia had been in contact with Children's Social Care, and that there had been serious concerns about her.

3.65 A number of agencies made referrals to Children's Social Care regarding their concerns for Julia and her sisters, including school, hospital, SARC, GUM and the police. These were all appropriate and were responded to by Children's Social Care as would be expected, but this did not lead to requests for further analysis and none of these agencies received information about the outcome of the Assessments emanating from these referrals, despite most agencies remaining involved afterwards. Coram explicitly asked to see the Assessment regarding Julia and her family and was told that permission would need to be sought from her mother. Mother's lack of engagement meant this never happened, and that Coram provided services in a vacuum.

[xli] Reder, P and Duncan, S (1998) Understanding communication in child protection networks: Child Abuse Review: Volume 12, Issue 2, pages 82–100, March/April 2003

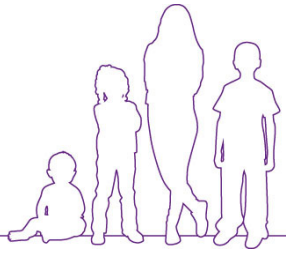


3.66 There were no multi-agency meetings over the two and a half years of the review. This meant that the drift in the case was not discussed, that services were provided in isolation from one another and there was no mechanism for reviewing the lack of progress, or deciding on an alternative plan of action. Meetings matter and they mattered for Julia and her outcomes.

3.67 There was evidence across the review that although working relationships were perceived to be good, there was often a lack of effective challenge across the professional network. The delay in seeking a Strategy Meeting in November 2010 caused by the inability to contact the police officer, was frustrating for the social worker and ultimately this delay meant no Strategy Discussion occurred. This was not discussed or challenged. The allocated social care team manager tried to escalate the case to Child Protection, and the emails were not responded to. At the time there appeared no mechanism to address this. The school made a referral to the Duty Team at Children's Social Care which was not responded to and was not challenged. Effective challenge is a critically important part of good multi-agency working.

How do you know it is underlying?

3.68 It is unclear whether this is an underlying issue. The Case Group told the Review Team that there were good working relationships in Thurrock across professional networks, and there were effective working relationships which had built up over time.



Finding 6

Information sharing is a critical component of multi-agency safeguarding practice, but if multi-agency processes are to be effective there is a need to move beyond the provision of information to sharing and exploring a professional analysis of a child or young person's circumstances. Assessments and plans need to be developed and reviewed by the multi-agency network. If this does not happen children and young people are left at risk of harm, and plans become one dimensional. Drift is not challenged, and the lack of progress not noted or addressed.

Questions for the Board

Do the Board accept this finding?

How will the Board establish whether this is a significant issue?

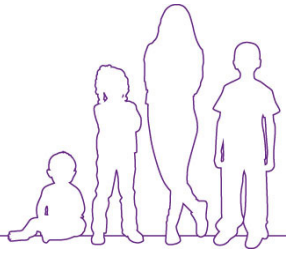
What can the Board do to address it?

How will the Board know it has been successful?

Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by others or themselves as an integral part of the safeguarding network?

Why does it matter?

3.69 General Practitioners have a critical role to play in safeguarding children and are vital to inter-agency collaboration in Child Protection processes and to promoting early intervention in families. There is considerable advice to support GPs in their safeguarding roles with children, especially concerning confidentiality and their duties as a GP and doctor, from the regulatory and professional bodies and



Royal Colleges (e.g. GMC, RCGP, RCPCH, BMA). Despite this, research[xlii] and serious case reviews[xliii] have highlighted that it is often problematic to engage GP's in safeguarding processes. This concern is characterised by the difficulties in obtaining information and attendance at key meetings, such as Child Protection Case Conferences.

3.70 Research suggest[xliv] that GP's are aware of their responsibilities regarding the safeguarding of children and young people, but that there are a number of systemic gaps which makes engagement difficult. This research highlights that GP's are concerned about the large reports they receive regarding children, which they do not have time to read or analyse. Where there are medical concerns about children, GP's are used to receiving succinct and focussed reports, which give a clear account of the main issues and the proposed plan of action, including their role. They argue that much of the paperwork they receive regarding safeguarding is lengthy and they cannot get a clear idea of the key issues, or the role that they are required to play. GP's are required to give six weeks' notice to cancel clinics, and find it difficult to attend meetings at particular times of the day, because of patient appointments, yet they feel little account is taken of this when they are asked to attend meetings. Research[xlv] also suggests that some GP's have lost confidence in the safeguarding system because of delays or a non-response to the referral that they make to Children's Social Care.

[xlii] Tompsett, H., Ashworth, M., Atkins, C., Bell, L., Gallagher, A., Morgan, M., and Wainwright, P. (2010) The child, the family and the GP: Tensions and conflicts of interest in Safeguarding Children. DCSF Research Briefing. London: HMSO.

[xliii] Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., and Megson, M. (2012) New learning from serious case reviews: a two year report for 2009-2011. London: HMSO

[xliv] Tompsett, H., Ashworth, M., Atkins, C., Bell, L., Gallagher, A., Morgan, M., and Wainwright, P. (2010) The child, the family and the GP: Tensions and conflicts of interest in Safeguarding Children. DCSF Research Briefing. London: HMSO.

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How did it manifest in this case?

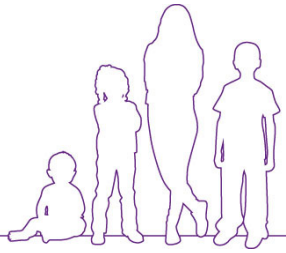
3.71 Julia was seen on six occasions by the GP's at her local Health Centre regarding under age sexual activity, the need for sexual health advice and concerns expressed by her mother regarding Julia's behavioural difficulties. The GP surgery made no contact with any of the other agencies involved with Julia or her siblings. The Assessments carried out regarding Julia acknowledged the GP, but the GP surgery has no record of any contact with Children's Social Care, they did not know Assessments were being undertaken and did not receive a copy or a summary of the analysis, or proposals for sexual health advice and support. No other agency made contact with the GPs, despite, for example, the school knowing that Julia's mother was seeking GP advice and support. The GP surgery was unaware that Julia was a Child in Need and therefore they were not able to inform anyone of their referral to Child and Family Consultation Services. During the period under review they worked in isolation. They did not seek to connect with the multi-agency network charged with promoting the welfare of Julia and they were not ever engaged in that network. This meant that important historical information that they held, particularly about Julia's mother learning difficulties, got lost and they provided sexual health advice without ever contextualising this alongside the other concerns regarding Julia.

How do you know it is underlying?

3.72 The Case Group told the Review Team that they considered that there were often difficulties engaging GP's in safeguarding work. The GP's who work in the Health Centre raised similar issues about their work in safeguarding to those highlighted in the national research.

How widespread and prevalent is the pattern?

3.73 It has not been possible to gather data about how widespread this issue is, but the Case Group suggested that this is a significant issue. The GP surgery was clear that the issue raised by them were replicated in other GP surgeries and national research suggest that this is an important issue to address.



Finding 7

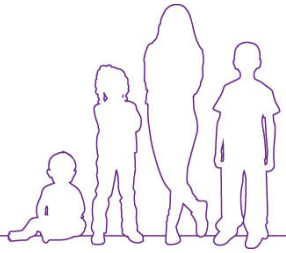
GPs are a critical part of the safeguarding network. It is essential that any barriers to their effective engagement in safeguarding processes are actively addressed. This is particularly important in the context of underage sexual activity and sexual exploitation, where GP's are likely to be a key point of contact for young people.

Questions for the Board

How will the Board establish whether this is a significant issue and which needs addressing?

How will the Board explore the engagement of GPs in the safeguarding network?

What are the options for addressing this issue?



CHAPTER 4 – ADDITIONAL LEARNING

1. The importance of holistic assessments

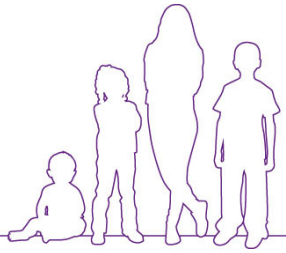
4.1 Historically national guidance regarding Initial and Core Assessments encouraged Social Workers to be incident focused and only analyse the circumstances of the referred child, leaving other children in the same family without a clear analysis of their needs or a plan

4.2 There were two referrals regarding Julia's sibling during the period under review and both focussed on the sibling rather than Julia. The Review Team recognised that the existing processes regarding Assessments did not support a holistic whole family approach. This is in the process of change with the development of the Single Assessment process.

4.3 In September 2011 Children's Social Care received a referral from the hospital regarding Courtney who had been seen in A&E with burns caused by her sister throwing water from a boiling kettle on her back whilst she was in the bath. The referral also said that the hospital was concerned because Julia's mother had told them that Julia "*had been sexually active since she was 11- 12 years old*". A referral was opened regarding Courtney, but not Julia.

4.4 The completed Assessment contained a lot of information and family history. The focus was on Courtney and her circumstances, but there was also information provided about Julia. Information was provided about Julia not having contact with her father because her mother said that he is a risk to children and was allegedly involved in the sexual abuse of a child. The School were said to have raised concerns about Julia who was refusing to follow instructions, truanting from class, being disruptive and had hit another student in class. In the context of the two previous disclosures of rape and the allegations made in the referral, these were worrying issues, which indicated that Julia had significant needs.

4.5 Crucially the conclusion of the assessment focussed almost exclusively on Courtney and the incident which led to the referral. This meant that the referral



was not considered to have met the threshold for services because the incident had been dealt with. Julia's needs were not analysed and no formal plan of action was put in place, beyond continued support from school for her.

4.6 The lack of any Assessment of Julia's needs during the majority of the period under review meant her needs were not well understood, the issues of sexual abuse not explored fully and the need for Child Protection processes to be put in place not fully discussed.

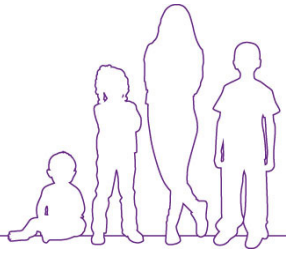
Issues for the Board to consider:

- Does the Board recognise that the quality of assessment in Thurrock is an issue for the safety and wellbeing of children and young people?
- Does the introduction of the Single Assessment provide an opportunity to improve the quality of assessments, and ensure that a holistic approach is taken?
- Does the Board have any evidence about the quality of Assessments locally and what the barriers to effective practice might be?
- Does the Board have an awareness of the key issue for effective assessment of young people who are being sexually exploited and what needs to be put in place to optimise assessment practice in this area?
- How will the Board know it has been successful?

2. Difficulties in escalating to concerns about Adolescents to Child Protection

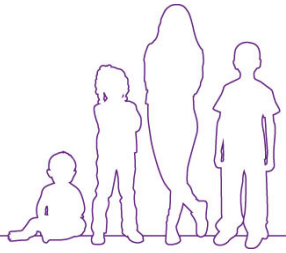
4.7 Over the period of the review the Case Group told the Review Team that adolescents were less likely to be subject of Child Protection processes and the social work team charged with meeting the needs of teenagers found this frustrating. This has changed over time, and there is now better recognition of the importance of Child Protection processes for this age group.

4.8 Given the seriousness of the concerns regarding the disclosure of sexual assault by Julia from the ages of 12 – 14 years, and her mother's unresponsiveness, it would have been expected that she would have been subject to Child Protection procedures. Julia made four disclosures of rape in a



two year period. Rape of a child is sexual abuse, yet somehow this was not recognised. The police undertook extensive criminal enquiries to establish the facts of each case and to seek a prosecution of the perpetrators identified by Julia. The lack of a criminal prosecution should not have meant that there was no assessment of significant harm and a decision made about whether a Child Protection response under Sec 47 of the Children Act 1989 was required.

Issues for the Board to consider:
• How will the Board know that these changes have occurred and are embedded in practice?



Thurrock Local Safeguarding Children Board Initial Response to the Serious Case Review

Introduction:

The publication of the Serious Case Review of "Julia" has learning for all organisations involved both locally and nationally.

The SCR is 52 pages in length and covers the period between November 2010 and February 2013. The report contains seven findings and specific challenges to which the LSCB will seek reassurance of change.

The case was referred formally to the Thurrock Local Safeguarding Children Board (LSCB) on 10th January 2013 and their Serious Case Review Panel met on 4th February 2013 to consider the case under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The Panel found that this case met the criteria for a Serious Case Review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children, 2010

At the time of this referral Working Together 2013 was about to be implemented which allowed LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology.

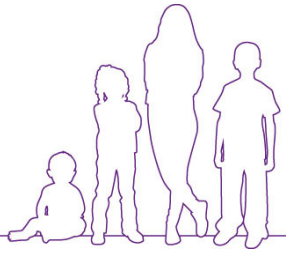
After considering the options for the review, it was decided to hold off the commissioning of the review under the "old" IMR procedures pending the guidance implementation to enable the board to commission a systems based approach for this SCR. In May 2013 the Board formally commissioned an independent and co reviewer using the SCIE methodology.

The findings within the report have been agreed by the LSCB Full Board on 19th May 2014 and service improvements are already in hand.

Since the period in question most agencies have demonstrated a clear commitment to learn and improve and have provided evidence to this effect to the LSCB and its sub structures.

With regard to the specific challenges of this serious case review, the LSCB has sought answers to the questions and supporting evidence from all agencies. Having agreed the findings the SCR Group met on 6 June 2014 and each agency has agreed an action plan of the challenges and where changes have not yet been effected, the commitment to make such necessary changes and improvement in practice is detailed within these plans.

Many of the agencies acknowledge that they need to do much better when listening to children and how this is reflected in the actions they take to safeguard and protect.
The Board is focusing on this as a priority area for improvement over the coming year.



This detailed response will be actively monitored by the Board, through its Audit Group to provide continuing evidence of impact.

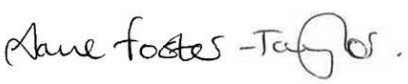
The LSCB will continue to maintain focus on how agencies are managing organisational change and ensuring safeguarding remains a priority.

LSCB key actions going forward:

The Board will carry out its responsibilities to co-ordinate and monitor the safeguarding arrangements in Thurrock and aims to ensure agencies are transparent within their own organisation, with its partners and the public and the children and young people with whom they work, by requiring that:

The LSCB will:-

- via its Audit sub group provide an evaluation of the progress of the responses by agencies and challenge agencies to produce evidence to determine there has been an impact for children.
- The Board will check that agencies responses have been factored in their improvement process and safeguarding reports to the Board and included in the 2015/16 LSCB Annual Report.
- Coordinate a multi-agency learning event available for all organisations to attend to disseminate the learning from this review.
- Request each organisation to provide details to the Board of the improvements emanating from this SCR within their agencies Annual Report.
- The LSCB training programme will be reviewed to reflect the findings. The Board will produce a presentation (PowerPoint) and briefing notes that can be cascaded to all agencies for use as part of organisational learning and included on its website. Agencies will be encouraged to make available time for their practitioners to access the report and absorb the learning.



Jane Foster-Taylor
LSCB Vice-Chair
14th November 2014

A summary of the response to the findings:

Following the Board meeting where the findings were agreed each agency was asked to respond. This proved to be a longer piece of work than the Board and Serious Case Review Panel originally thought it would be. Some of the findings are phrased as a question to the LSCB and agencies. This is a feature of this method of review and reflects the fact that the hard evidence was not readily available but that the Reviewers, the Review Team and Practitioners had a sense that this was the situation. In formulating the detailed response no evidence to counter the questions completely was found and so they are accepted as areas that need development.

The result is a detailed action plan which is quite long therefore a brief summary of the nature of the responses is below. The plan is being actively monitored by the LSCB and a Sub-Group and is available on request to accompany the serious case review report.

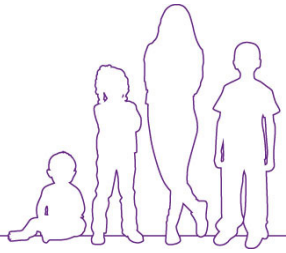
We need to acknowledge that whilst the responses have been put together the Rotherham Report (Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013) by Alexis Jay OBE) was published and we have started work with our neighbouring Essex Boards and the partners to ensure that our previous plans around child sexual exploitation (CSE) are still fit given the issues highlighted in this new report. To help with this a new strategic group has been formed to consider the report and the all Essex CSE group, under a new Police chair, is considering all aspects of CSE. There is also a Thurrock CSE group in place to ensure the local perspective is properly considered.

Tackling the issue of child sexual exploitation was and remains a high priority for Thurrock LSCB and the individual agencies.

The move away from a series of simple recommendations made by a reviewer to findings which need to be worked through by the multi-agency partnership is challenging. It is also a shift in thinking to try and come up with some responses that are more than just “train the workforce”. Whilst we have a detailed response and actions from agencies this is not the end of the response to the findings but a starting point for Workforce Development to address the matters found by this review. The summary below and the full agency response should be read with this in mind.

That said, training the workforce and sharing findings from a review remain important tools. As an LSCB we are looking hard at how we measure the impact of any training that is delivered and our latest full LSCB meeting ran with a theme as to how individual agencies know that training is making a difference to peoples’ practice and therefore making a difference to children.

Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual exploitation



This issue was widely acknowledged by partners and in particular people who work in health and deal with children and young people.

There was already in place a programme of training to help staff recognise when someone might be at risk of being exploited which was happening whilst this review was being done. There is more work to do around this to ensure there is a good understanding of the issue amongst all professionals and that any response is consistent and timely across the partnership.

Thurrock has recently "gone live" with a Multi-Agency Safeguarding Hub (MASH). This puts a number of people from different professions into one place to consider any concerns about children and young people. This model is recognised as being a strong tool to help recognise and deal with child sexual exploitation.

The House of Commons, Home Affairs Committee, Child Sexual Exploitation and the response to localised grooming, Second Report of Session 2013- 14 said:

"We recommend that each Local Children Safeguarding Board be required to set up a Multi-Agency Safeguarding Hub which would house representatives from Social Care, local police, health professionals, education, Youth Offending Teams and voluntary organisations…The police and the CPS should also produce guidance on data sharing via the MASH… "

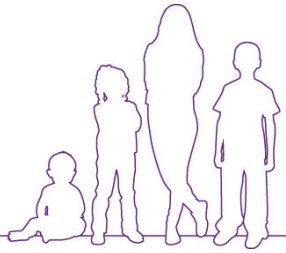
The LSCB will be monitoring the results of this new structure to ensure it is making a difference to the children and young people of Thurrock.

Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection

Unfortunately this is not a new issue and has been highlighted in other reviews. The nub of this is about children and young people using words like "relationship" and adults thinking about that in an adult way without exploring what the child really means.

Again the new MASH will help but there needs to be a broad understanding of this amongst people working with children in many situations. A workshop is planned by some health colleagues. The response from agencies shows a commitment to change and challenge people's use of language.

Individual supervision and the LSCB multi agency audits will consider this issue to ensure that there is a clear analysis of what the professional has been told.



The LSCB ran a conference last year with a theme of hearing the voice of the child and a more recently a themed LSCB meeting in March 2014 asked agencies to report on how they hear the voice of the child and ensure what they hear makes a difference to practice.

The detailed action plan in response to this finding builds on this earlier work.

Finding 3: Is there a pattern whereby the Child in Need (CIN) procedures are not routinely being used leaving children and young people without formal plans and review?

Whilst all agencies are involved in these processes the lead here is Children's Social Care. It was recognised in a mock inspection done is November 2013 that adherence to CIN processes, particularly in regard to regular review was not established, predominantly in the Adolescent Support Team.

Since then action has been taken to address this before this review was finalised. New processes have been put in place including supervision to help discuss and challenge the response to the young person.

In order to conclude this finding the LSCB needs to be satisfied that these new procedures are the normal practice for everyone and those children and young people have appropriate formal plans and reviews. The LSCB will monitor this as part of the Performance Sub Group and report back to the Full Board.

Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response

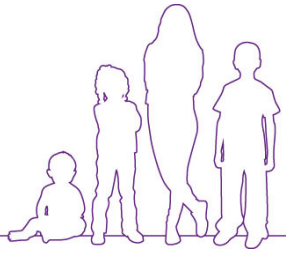
Resistant parents are well known to be a blocker to working with children and young people and this is recognised by all the LSCB agencies. Training has previously been undertaken.

The Early Offer of Help approach of starting work earlier with a family may help, dealing with "missed appointments" of children by health workers may also help. Appropriate early escalation for supervision and a multi – agency response could also assist.

The LSCB needs to closely monitor this finding to be sure that suitable mechanisms are in place to recognise and deal with resistant parents. This is a complex issue for which there is not a "quick fix" such as training alone but needs a range of tactics.

Monitoring the situation is also a challenge and the LSCB and the sub-group will continue to consider what work could be done to assist professionals working in these circumstances so that the best possible outcome can be achieved for children and young people.

Finding 5: Is there is a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm



It is agreed that the impact of adolescent neglect is not always fully understood by professionals and perhaps not dealt with as firmly as neglect in younger children. Some behaviour that could be part of a pattern of neglect could also be seen as part of adolescent behaviours where there is not neglect.

The LSCB is undertaking a new serious case review where neglect of an older child is a feature which reinforces the fact that this is an area of practice that needs to become better developed.

The annual conference, due in the autumn of 2014 has a focus on neglect and adolescent neglect will be part of that. This will help in increasing awareness of this also there is a cross over with child sexual exploitation work where older children, those aged over 16 but under 18, can be particularly challenging for professionals to work with.

Some training is being planned and Children's Social Care are working with a new assessment tool to help recognise the neglect of adolescents.

Finding 6: Is there a pattern whereby Multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?

Put simply this finding was suggesting that people were sharing information as they should but not getting to the heart of the matter by really thinking about what the information was telling them about a situation.

Part of the remedy to this is to make sure each agency shares their information including their own analysis.

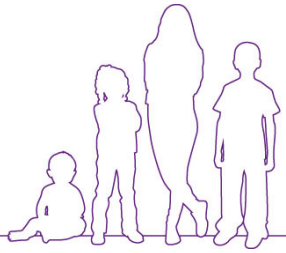
The MASH should assist greatly in this and we are eager to start seeing the performance data that will be produced so we can see what a difference it is making.

A good shared analysis should lead to better planning, the end result being the right children having the best response at the right time, for only as long as it is actually needed. We can determine if this has happened by undertaking audits of cases as part of audit programme.

Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by other professionals or themselves as an integral part of the safeguarding network?

Part of the response said that most GP's *did* recognise themselves as being part of the network. So this finding is not fully accepted by all agencies. However it remains a challenge to consistently engage all GP's, this is recognised by some of the practitioners as they have made suggestions as a result of this finding as to how they might better be able to contribute.

The LSCB needs to undertake some work to see how widespread the issue actually is to make sure any effort to correct this is focused in the right way. The reasons could be many and



diverse and it is likely there needs to be a re-think as to how best to work with GP's to ensure their important contribution is included every time.

There is now improved engagement with Primary Care with over 90% of Thurrock's GPs trained to Level 3. There is 100% Board level awareness for Thurrock CCG and currently Section 11 Audits are being undertaken. Also a Named Safeguarding Doctor for Thurrock CCG has now been appointed.