Child 2
Learning Tool

Introduction

This **Briefing Note**, based on a review of a Luton case involving a young person who regularly went missing from home where child sexual exploitation was also a factor has been circulated purely as a Learning Tool. The review undertaken was not a serious case review, but a multi agency review to identify learning opportunities.

This **Briefing Note** is intended for use as a discussion and learning tool in staff/team meetings across the Luton Safeguarding Children Board Partnership. Please note, the report has been 'anonimised' to protect the young person, her family and professionals involved but with sufficient narrative to provide context and time lines to aid discussion and inform learning.

Key Lessons for improving practice

1. This review has highlighted the sort of difficulties that face professionals in working with children and young people who are at risk of sexual exploitation. These need to inform future work with this group of young people and local forums focusing on cases of CSE.
2. Working with difficult and uncooperative service users should heighten the need for supervision discussions and close working arrangements between agencies.
3. Arrangements for identifying GPs in child protection cases and informing them when a child is subject to a child protection plan must work consistently.
4. Agencies should consider how to develop a style or system of working that enables young people to form stronger working relationships with a professional or small group of professionals over a longer period of time.

Summary of key events and professional involvement

- Child 2 (Born 1997) was not born in the UK, but moved here as a young child. She has 2 younger siblings, all three children are the product of both parents, although there is a gap of some 8 years between Child 2 and younger siblings.
- Child 2s school attendance was 93% in 2008/09 and 87% in 2009.
- Professionals were involved with Child 2 in relation to four sets of concerns:

1. She went missing on many occasions, beginning in late 2010 shortly before she was 14

2. She made allegations of physical assault against her parents. Her mother accepted a police caution in early 2011 as a result of the first allegation. Her father denied or refused to answer questions about these allegations but was convicted of assaulting a police officer as a result of an incident that occurred during police contact over Child 2.
3. Child 2's father made allegations that she was being lured into having sex with a number of adult males in Luton. These allegations were never documented or investigated in detail by Bedfordshire Police, however they were viewed as being likely to be true in that 1) Child 2 agreed that the events had taken place, though she refused to make allegations of abuse or discuss them in any detail 2) there are numerous references to Child 2 being 'sexually active' and she had a termination in 2011 3) the focus of significant health interventions was on 'harm reduction' in relation to this reported sexually activity
4. Child 2 made a number of allegations of rapes that were said to have occurred when she was missing from home. These were investigated by the police and on all occasions it was believed that these were false allegations that had been made in order to try to diminish her parents' anger and to distract attention from the fact that Child 2 had gone missing.

- The local authority was involved with Child 2 between November 2010 and May 2011 when the intervention was led by a Specialist Support Team (SST). This followed the first reported parental assault on Child 2. The contact was then closed on the basis that there had been improvement in family relationships.

- Following further substantiated allegations of assault by her father, Child 2 was made the subject of a child protection plan between January and July 2012. The SST again led the social care intervention and there were reports of improvements in relationships within the family. However these did not last after Child 2 was removed from the child protection plan. Shortly after this the SST withdrew its involvement, on this occasion not because of reported improvements but because of a reported lack of parental cooperation.

- Between July 2012 and June 2013, the local authority kept the case allocated as a child in need. The local authority social worker has said that she was monitoring Child 2's case during this time. However, at times during this period some agencies state that they did not know that the local authority social care service was still involved. The social worker had a caseload of up to 34 cases during this time and her team had two different interim managers.

- From September 2012 onwards, Child 2 experienced worse problems and started to go missing again. At this stage her school became the main focus for holding meetings and coordinating support. The school nurse and other health professionals became more involved seeking to provide advice and services that would reduce the harm arising from Child 2s behaviour. Both the GP and the school made referrals to CAMHS in order to offer counselling over her experience of sexual and physical abuse, but both of these referrals were refused on the grounds that:

  - GP referral - Child 2's behaviour was possibly an 'understandable' reaction to her experience of sexual abuse and that she should be seen for more informal counselling and re-referred to CAMHS if she continued to have difficulties;

- School referral - On the grounds that there were current 'safeguarding issues'.

- The probation service became involved with Child 2's father in November 2012 as a result of his conviction for assault a year before (the delay being due to the fact that he had appealed unsuccessfully against his conviction).

Learning from the review

Difficulties in working with the young person and family

- It was recognised that there were a number of features of the case that had made it very difficult for professionals to work with the child and her family.

- Professionals specifically described many of the contacts with the father as being 'bizarre' (in that he spoke largely about himself rather than his daughter and was very angry and distrustful of about agencies). The mother's attitude and behaviour are less clear from records and professionals accounts. At times there are reports of delays in reporting Child 2 missing or the family reporting her missing to the school, rather than the police. The only agency that the father appeared to trust was Child 2's High school.

- With hindsight neither the parents' nor the young person's motivation or the impact of their cultural backgrounds appear to have been explored (until the father became involved with probation service).

Appearance of improvement, then deterioration

- At a number of points in the case history there were brief interventions made in response to the presenting difficulties and crises in the case. These appeared to have achieved some success which was usually lost when the professional intervention ended.

- There was no evidence of an evaluation of the reasons for these difficulties. One reason for this was that the only core assessment of the case was undertaken during the first Section 47 enquiry and that during the following two years it was not revisited or updated.

Assessment of relevant cultural factors

- The probation officer who worked with Child 2's father immediately identified possible cultural factors that might account for his hostility to the state and the police. This sort of understanding was not apparent from the material provided by other agencies, despite their lengthy involvement. The SST allocated black workers to the team but the value of exploring the family's specific cultural background does not seem to have been made explicit. Given that Child 2's father had fled police brutality in a totalitarian state it was not surprising that he reacted with anxiety, anger and suspicion to state interventions in the UK. It was very disappointing that this was not a major feature of the work with the family.

Coordination through child in need plan

- During periods when the child was subject to a child protection plan the work was responsive to new developments and concerns – for example Child 2 moved out of

Luton and then out of the UK. Agencies discussed and evaluated these concerns and responded appropriately to the risks that were identified.

- Local authority managers who attended the review explained the arrangements for 'stepping down' to a child in need plan once Child 2 was removed from the child protection plan. They indicated that because of the pressure of workload the social worker would usually only remain involved for a limited time before closing the case. In this case however, the social worker had remained involved but so far as other agencies were concerned had not been effective in coordinating the provision made to Child 2.
- After July 2012, it was not clear from the chronology or from the information presented to the review meeting what the child in need plan was. The Luton High School staff did coordinate a number of meetings, although the school did not always know which agencies were involved. Other child in need meetings were coordinated by the social worker, but not all of the agencies involved were always invited.

Thresholds for intervention

- After September 2012 there were repeated concerns about Child 2 going missing and (according to the concerns strongly expressed by her father) having sex with adults. Information was known to both police (rape investigation team) and the local authority. Although Child 2's position was deteriorating there was no evidence of a decision or pressure to consider whether Child 2 was at risk of significant harm and a child protection conference needed to be convened.
- Following a period (December 2012 – January 2013) when there were few incidents reported in the chronology the local authority was noted as saying on a number of occasions that there appeared to be 'no statutory role' for social care.

The meaning and causes of Child 2's behaviour

- There was some evidence that Child 2 had a good relationship with staff at her school and asked for their support and involvement (for example when meeting new professionals).
- None of the evidence presented to the review indicated that professionals had managed to understand from Child 2 herself why she was running away and putting herself at risk.
- The interventions made by health staff focused on harm reduction were useful but did not address this wider picture. The work undertaken by the SST focused largely on parenting. The SST interventions and the role of the social worker were time-limited and task-focused.
- Reviewing the work undertaken with Child 2 there is a case that while she benefited to some degree from the large number of short term interventions focused on specific problems she might have benefited more from being able to form an attachment to some consistent or more stable figure who could gradually gain her trust.

Police interventions in relation to rape allegations and missing persons

- Activity in relation to Child 2 as a missing person followed the expected procedures. Follow up visits were made on her return and the local authority was normally informed. In March 2013 there was a delay in liaison between the missing persons officer and the social worker because the police officer referred Child 2 to the Sexual Exploitation Risk Assessment Conference (SERAC) forum, naming the social worker as an involved professional. She explained to the review meeting that she had understood that this would lead the social worker to be informed about the fact that Child 2 had been missing for some days. She had simply misunderstood a new procedure.
- The mother and father made allegations that Child 2 was having consensual sex with older men. Father felt strongly about this but he appears to have been unable to successfully convey his concerns to the police. These allegations were never reported directly by Child 2 and so far as can be established were not explored by the police in any detail. No additional intelligence was gathered in relation to these potential concerns.
- Child 2 made rape allegations when she returned from being missing and then withdrew them. Because they were withdrawn and because they were clearly contradicted by other evidence they were not viewed as symptomatic of wider problems.
- The local authority was told that there had been rape allegations. On one occasion the social worker appears to have left it to the police to decide if a strategy meeting was necessary. On another a strategy discussion was held after some delay. As a result there was no multi-agency assessment of the risks to Child 2 at that point.

Information sharing with the GP

- Child 2's GP did not know that she had been made the subject of a child protection plan. It appears that the GP was not identified in the referral or Section 47 investigation or after the child protection conference. This had implications for the care that could subsequently be provided to Child 2.
- The GP records also did not contain any reference to Child 2 having had a termination, presumably because it was arranged privately and the GP was not notified. This will always be a potential risk.
- As a result of these two omissions the GP referral to CAMHS seeking therapeutic support for Child 2 missed important information.

Narrow focus of the work in the case

- The focus of concern was always narrowly on presenting aspects of Child 2's difficulties. For example: 1) There was no referral on the mother (who worked with vulnerable adults) to the LADO or adult safeguarding after her caution for assault. Even if she does not present a risk to adults that risk should have been evaluated 2) At no point during the work with Child 2 was there evidence that consideration was given to the impact on the welfare of the other children in the household and 3) At no

point during the work with Child 2 was there evidence that consideration was given to the possibility of sexual abuse within the family.

Strengths in practice identified

A number of strengths were identified in the work:

- Good application of arrangements and procedures for missing persons
- Good work by Luton High School in attempting to build a relationship with Child 2 and to coordinate assistance for her
- Good availability of advice and assistance in relation to sexual health from school nurse and other health professionals.