Surrey Safeguarding Children Board

Report of the Serious Case Review regarding Child D

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Executive Summary

Background and Incident

In October 2019 the LSCP commissioned a review into the serious harm of a child [known as 'Kate' within this review] following the conviction of her abuser in 2018 for numerous sexual and violent offences. Whilst the abuse was uncovered and prosecuted in the North of England, the majority of offences took place when Kate was aged 11-16, living in the Home Counties and in receipt of health and social care interventions due to concerns regarding her welfare.

The period under review is from June 2013, when concerns about Kate's welfare arose, to 2017 when her abuser was arrested and prosecuted. The review was asked to consider how well agencies worked together to support Kate and her family in 2013 and respond to concerns raised regarding Kate's emotional and physical safety, particularly in relation to grooming and sexual abuse.

Terms of Reference in Brief

The report seeks to respond to the following questions

1. Did agencies work well together to offer appropriate support following Kate's bereavement?
2. Did practitioners respond appropriately (namely, in accordance with relevant statutory guidance) to concerns raised regarding Kate's emotional and physical safety, particularly in relation to grooming and sexual abuse?
3. How robust was the Child Protection process, including whilst Kate was subject to a Child Protection Plan and Missing and Exploited Children's Conference, in identifying and addressing the risk of emotional and physical safety and sexual exploitation?
4. What is needed to improve future practice and ensure effective inventions to protect young people at risk from people in positions of trust?

Summary of Findings

The initial response from specialist services did not take into account Kate's high level of distress or work in a coordinated way with universal services to address identified risks associated with the reports of parental neglect and the impact this was having to address Kate's needs. Too much reliance was placed on onward referrals without checking those agencies were able to support Kate and her mother, or indeed whether her mother would comply. No expectations were set by CSC for Kate's mother to change behaviours so as to meet Kate's basic needs. No exploration was made of the triggers for Kate's self-harming behaviours; had this been explored in line with the principles and parameters of a good assessment, Kate confirmed during conversations with the reviewer, it is highly likely she would have disclosed CD was already sexually abusing her.

The investigation in 2013 into grooming and abuse by CD was not sufficiently robust given what was known of the likely presentations at the time. Information was not shared appropriately between agencies or with Kate and her wider family, despite the significant role they were given to act in a protective capacity. Insufficient weight was given to the

voice of the child and concerns raised by her family members. The decision to refer Kate for a Youth Intervention for wasting police time was not consistent with national guidance in force at the time.

Practitioners were aware of the potential risk indicators of sexual abuse and recognised how her mother's neglect and Kate's isolation increased this risk. Their response to the identified concerns was wholly inadequate. Despite a high number of professionals and all key agencies having been informed of the risk, coordination was severely lacking. Information was not gathered in a way that facilitated effective shared risk assessment or managed to reduce or prevent abuse. There were too many handovers with little or no follow up to ensure that those receiving referrals had the information or skills to support Kate. Information was not gathered in a way that facilitated effective shared risk assessment or managed to reduce or prevent abuse. There were too many handovers with little or no follow up to ensure that those receiving referrals had the information or skills to support Kate.

Summary of recommendations

The purpose of any serious case review is not to replicate civil or criminal processes or to apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately to improve the safeguarding and wellbeing of children and young people in the future. Findings and recommendations from this review are not intended to dilute or deflect culpability for the harm caused to Kate from both the neglect and sexual abuse she suffered whilst a child.

Policy

1. The LSCP update their multi-agency procedures to ensure greater focus on pursuing perpetrators, explicit references to statutory thresholds for investigations and legal remedies (including all civil and criminal orders) and the burden of proof or use of collaborative third-party information.

2. The LSCP may wish to include guidance to child protection practitioners on accessing advice from agencies with expertise in the management of offending behaviours on possible risk reduction measures.

Assurance

3. LCSP conduct an audit/ review of the police decision making in respect of the out of court disposal for wasting police time should be undertaken and consideration given to expunging Kate's record.

4. The LSCP should seek assurance that the Police and Youth Offender Services have reviewed records of other known victims of grooming and sexual abuse and rectified these accordingly.

5. The LSCP should seek assurances that social workers, CP conference chairs and police officers involved in child protection duties have received training and apply relevant guidance when interviewing children and young people, potential witnesses (including

family members) and alleged perpetrators where there is a risk of grooming and sexual abuse.

6. The LSCP seek assurance that universal services and CSC practitioners are routinely utilising the Graded Care Profile2, or similar practice tools and the CE risks assessment toolkit to measure and monitor parental/ carer capacity to recognise and respond to risk of sexual abuse, neglect and parental substance misuse.

7. The LSCP establish mechanisms to monitor tracking of cases that are stepped down from PLO pre-proceedings work and those removed from CP and CIN processes where risks include sexual abuse, substance misuse and/or neglect.

8. LSCP monitor arrangements for cross boundary information sharing and outcomes of LADO investigations, particularly where this indicates a Barring referral should have been made to the DBS service.

9. The LSCP seek assurances from health providers and commissioners that trauma informed therapeutic support is available locally to young people (including those over 18 who experienced abuse as children) and their extended family.

10. The LSCB disseminate to relevant agencies and seek assurance staff, including designated safeguarding leads in schools, school nursing service, voluntary and charity sector organisations received a briefing on this review and have identified ways to improve practice.

Workforce development and awareness raising

11. LSCP should consider a multi-agency practitioners' workshop or skills-based programme to enhance shared understanding of the legal framework available to disrupt perpetrators and protect children at risk of sexual abuse.

12. LSCP to raise awareness of the Office for Civil Society's and NCVO's on-line resources for organisations and charities providing services to children and adults at risk to ensure safer recruitment practices and effective safeguarding investigations.

<u>Supporting victims of Grooming and Sexual Abuse by People in Positions of Trust: Report into the Serious Case Review for a Local Children Safeguarding Partnership ['LSCP']</u>

In October 2019 the LSCP commissioned a review[1] into the serious harm of a child [known as 'Kate' within this review] following the conviction of her abuser[2] in 2018 for numerous sexual and violent offences. Her abuser was sentenced to 26 years in prison, he was also made subject of a lifetime Sexual Harm Prevention Order and will be on the sex offenders register for life. Whilst the abuse was uncovered and prosecuted in the North of England, the majority of offences took place when Kate was aged 11-16, living in the Home Counties and in receipt of health and social care interventions due to concerns regarding her welfare.

The period under review is from June 2013, when concerns about Kate's welfare arose, to 2017 when her abuser was arrested and prosecuted. The review was asked to consider how well agencies worked together to support Kate and her family in 2013 and respond to concerns raised regarding Kate's emotional and physical safety, particularly in relation to grooming and sexual abuse. In addition, the review will explore what the barriers were to implementing effective protection through the Child in Need, Child Protection and Missing and Exploited Children's Conference processes, including the handover when Kate moved away from the area. The review has also explored[3] what is needed to improve future practice and ensure effective interventions to protect young people at risk from people in positions of trust ['PiPoT'].

The LSCP and reviewer are extremely grateful that Kate was willing to contribute to the review. She has shown immense courage in doing so. At her request, specific members of her extended family have also assisted. Out of respect for Kate's wishes, Kate's mother has not been involved in this review. The perpetrator in this case has, since his conviction, made continued attempts to contact Kate; these have mostly been intercepted but, given the apparent lack of insight into the possible impact of his behaviours, no attempts have been made to include him within this review.

Those commissioning this review were keen to stress the importance of the 'voice of the child' in identifying and understanding the risk of sexual abuse and asked that particular focus be given to how well practitioners worked together to understand what life was like for Kate. Since 1992 the UN Convention of the Right of the Child has been in force in the UK. This convention requires state bodies protect specific rights of a child to be heard (article 12) and to ensure laws and systems are designed to ensure every child can develop to their full potential (article 4 and 6) including by living free of violence, abuse and neglect (article 19) and sexual exploitation (article 34). It is easy to see how statutory child protection duties[4] are shaped by these obligations, but the status of this convention means that these responsibilities should also shape decision making by all relevant practitioners working across universal services[5] and child protection agencies so that they actively protect children from harm. This is the context within which practitioners should work to secure the 'voice of the child'; doing so enables everyone involved in promoting a child's safe development to reflect very carefully on the underlying purpose of their relevant responsibilities and how their role fortifies statutory child protection duties.

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[1] In accordance with reg 11. of the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018. The name of the child and LSCP has been redacted in line with Kate's wishes for anonymity.
[2] In order to retain Kate's anonymity her abuser will be referred to as 'her abuser' or CD throughout the document.
[3] With input from some of the practitioners who were directly involved in the case and senior leaders now responsible for supporting frontline practitioners.
[4] Specifically the duties for the local authority to lead any investigation into concerns (s47 Children Act) and to cooperate with wider statutory partners (s11 Children Act) including the police where there is reasonable cause to suspect criminal offences may be committed.
[5] The term 'universal services' is used to describe services available to all children, such as schools, health visiting and GPs. https://www.scie.org.uk/publications/introductionto/childrenssocialcare/furtherinformation.asp

1. **Did agencies work well together to offer appropriate support following Kate's bereavement?**

1.1 Kate first came to the attention of the Local Authority's Children Social Care Services ['CSC'] in early Summer 2013 when concerns were raised by her school and GP that Kate had shown signs of physical/ psychological pain, including self-harming behaviours following the death of her father that year. She was 12. Her GP, extended family members and Kate herself raised concerns about her mother's alcohol use and the impact this was having on her ability to provide basic care to Kate. In addition, her family members had raised concerns, including to Kate's parents, regarding the level of unsupervised contact she was having with 'CD' (the man subsequently convicted of sexual abuse). Prior to making the referral, her school had invited Kate's mother and wider family members to a meeting to agree a plan of support to protect Kate. CD attended this meeting and when challenged by Kate's uncle, claimed to be supporting Kate's mother. Shortly after her uncle challenged CD, Kate confirmed she was told by him to make allegations against her uncle. She reported to her teacher she did not wish to stay with her uncle, as he had followed her to the bathroom. This information was reported within the referral to CSC, but not further explored. Kate confirmed as part of this review that all the allegations she made against wider family members were done because her abuser had told her what to say and threatened to hurt her or destroy items of her father's if she didn't.

1.2 Initially no additional support was offered; both Child and Adolescent Mental health Services ['CAMHS'] and CSC advised the GP and school to support Kate through bereavement counselling services. School staff and her GP persevered, referring Kate's mother for specialist intervention from alcohol abuse support services (initially unsuccessfully due to her mother's lack of engagement) and resubmitting further referrals in July to CSC and CAMHS reporting concerns by family members to continued incidents of significant self-harm and reports by Kate that she had suicidal thoughts. CSC, satisfied that CAMHS intended to offer an assessment but without having spoken to Kate or her mother, took no further action. At this time CD contacted CSC, explaining that he was the designated safeguarding lead for a voluntary youth organisation Kate attended and knew the family in a personal capacity. He requested information about the extent of CSC's investigation. CSC rightly advised that he seek information directly from Kate's mother.

1.3 At this time, Kate was also interviewed by the Police as a victim of contact sexual abuse by a Person in Position of Trust in 2007/8. Following the police investigation no action was taken. It isn't clear whether this information was available to CSC, but would likely have been if more detailed enquiries were undertaken at the time of the initial referrals.

1.4 In August 2013 the GP wrote again to CAMHS requesting an urgent appointment as Kate had taken an overdose. An initial appointment was offered 10 days later and Kate and her mother attended. Kate disclosed she had intended to end her life, that she was bullied at school, was arguing with her mother and felt she 'wouldn't be missed'. An internal review of the case notes reported Kate wasn't asked if she had experienced 'physical, sexual or emotional abuse at any time in her life' despite this being a key question within an initial appointment. By September 2013 CAMHS ceased their involvement (despite a failure by Kate's mother to attend a follow up appointment) reporting back to her GP that they had made a referral for bereavement support.

1.5 By 2013 much was already known of the likely presentations and impact of child abuse, as well as barriers that prevent children reporting abuse, especially sexual abuse. Thematic reviews already published by this time identified common barriers to effective child safeguarding.[6] These

[6] Broadhurst et al, (2010) 'Ten pit falls and how to avoid them: What research tells us' NSPCC available at: https://www.nspcc.org.uk/globalassets/documents/research-reports/10-pitfalls-initial-assessments-report.pdf highlights '*it is imperative*

highlight the critical importance for practitioners to not focus only on the most visible or pressing problem but to also pay attention to what children say, how they look and how they behave. It also warns against placing insufficient weight on information given from family, friends and neighbours. The report identified a dilution of responsibility in the context of multi-agency working; cautioning child protection agencies not to simply signpost to other agencies with no follow up. The relevant Council's Early Help Strategy from this time identified young carers, children experiencing parental and family issues and those living with parental substance misuse among those requiring '*support from children and families before problems escalate and reach crisis*'.[7] All of these issues were pertinent to Kate and, under the Council's 'multi-agency levels of need document'[8] would have required at least a level 3 targeted and timely intervention, namely consultation and advice from a specialist service following an early help assessment.

Finding: The initial response from specialist services did not take into account Kate's high level of distress or work in a coordinated way with universal services to address identified risks associated with the reports of parental neglect and the impact this was having to address Kate's needs. Too much reliance was placed on onward referrals without checking those agencies were able to support Kate and her mother, or indeed whether her mother would comply. No expectations were set by CSC for Kate's mother to change behaviours so as to meet Kate's basic needs. No exploration was made of the triggers for Kate's self-harming behaviours; had this been explored in line with the principles and parameters of a good assessment[9], Kate confirmed during conversations with the reviewer, it is highly likely she would have disclosed CD was already sexually abusing her.

2. **Did practitioners respond appropriately (namely, in accordance with relevant statutory guidance) to concerns raised regarding Kate's emotional and physical safety, particularly in relation to grooming and sexual abuse?**

2.1 In November 2013 CSC did agree to 'open a case' following disclosure by Kate of parental ill treatment and neglect. Shortly afterwards Kate also disclosed to school staff she had suffered multiple rapes including as a young child. She described the most recent attack having occurred a few weeks beforehand. She also disclosed to school staff that she thought she was pregnant and was experiencing pain. This prompted an immediate joint investigation between the police and CSC under s47 Children Act 1989, including a police interview in line with 'Achieving Best Evidence' guidance and a medical examination. The clinician carrying out the medical examination commented:

> '*although no abnormalities had been found this does not rule out the possibility of sexual assault having occurred as research show us that physical examination is very often normal even though there has been very clear documented penetration of both the vagina and anus.* ['Kate'] *is clearly a distressed young lady who appears quite unhappy and this may be her way of trying to tell us something of a sexual nature has occurred but she is finding it hard to tell us the exact detail.*'

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when making initial assessments that practitioners take time to see, speak to and observe children (Glaser, 2009) … *Moreover, seeing the child in the early stages of work must equate to more than just "ticking a box" and should constitute a detailed qualitative observation (Aldgate et al, 2006). Hart and Powell (2006) stated that a case file should give "a real sense of the day-to-day experiences" of the child. The practitioner should be able to picture what life is like for particular children in their families*.'

[7] Early Help Strategy 2013-17, Surrey County Council available at: https://www.surreycc.gov.uk/__data/assets/pdf_file/0011/27200/Early-help-strategy-2013-2017-FINAL-updated-template.pdf

[8] Launched in Spring 2013 and available at: https://www.whatdotheyknow.com/request/212709/response/529444/attach/4/11014%20Annex%201%20Levels%20of%20Need%20Document%20v%203.0%201.pdf

[9] Working Together to safeguard Children, HM Government, 2013 (accessed 29.01.20 at: https://webarchive.nationalarchives.gov.uk/20130403204422/https://www.education.gov.uk/publications/eOrderingDownload/Working%20Together%202013.pdf

2.2 Sommers review[10] highlights that visual forensic examination following a sexual assault rarely identifies genital injury. In some studies as few as 5.2% of victims had detectable gynaecological injuries. It is therefore crucial that child protection practitioners (particularly the police and social care) understand that a lack of injury does not rule out sexual abuse or child sexual exploitation and they do not put too much reliance on forensic examinations as the sole source of evidence. Clear guidance[11] is available for practitioners on the approach to take when investigating concerns regarding sexual abuse.

2.3 In conversations with the reviewer Kate expressed surprise that the examination had not found evidence of sexual activity. She confirmed that by this time CD had been sexually abusing her for some time. She spoke of the high level of intimidation she endured during this period, including direct threats by him to hurt her, the way he undermined her memory of her father and the coercion he employed to disrupt her relationships with extended family members by undermining their trust in her. She also recalled he would wait in his car and intercept her on her way to school. Kate confirmed within this review that the evening before she made the allegations, she had been raped[12] by him. He had texted her later that evening and, when she had not replied, he had waited for her early the next morning at the bus stop in his car and told her what she needed to say to deflect attention from him. She explained he drove her around and only let her out of his car to go to school when she agreed to act as he'd instructed.

2.4 Kate explained that she agreed to an internal examination understanding that it would provide evidence that she was being abused. She was aware he followed her to that examination and explained during conversations with the reviewer how frightened she was of repercussions from him, but also relieved. She believed this would be a turning point, because everyone would know she was being abused and so what happened next would be out of her hands. So when nothing happened, the results of the tests were not reported back and an investigation wasn't taken forward, she lost faith that she would be protected from his abuse.

2.5 Two days later Kate was admitted into hospital having taken an overdose and collapsing at school. During the review Kate explained she felt it was the only way to get away from the abuse. Following a request by the treating psychotherapist, CSC agreed to complete a joint assessment. The psychotherapist who supported Kate during this period did contribute to this review and spoke of a clear sense from Kate of a child in notable distress who '*did not feel believed*'. Her case notes from late 2013 describe having to reassure Kate, because her earlier experiences in summer 2013 were of services having '*walked away*'.

2.6 Early within the police investigation into the rape allegations, officers separately formally record safeguarding concerns regarding contact between Kate and CD. This was prompted when the allocated social worker shared concerns with the police that he had again contacted CSC for information in respect of the investigation on hearing that Kate had been admitted into hospital. In response the police considered whether Kate was at risk of sexual harm from him. This consisted of carrying out checks of police records in respect of CD and seizing Kate's phone. His phone was not reviewed and nor was he interviewed. The allocated social worker did challenged CD, asking if he felt it was '*appropriate to be texting a 12 year old girl*'.[13] Notification was made to the Local Authority Designated Officer ['LADO'] to carry out enquiries, but these concerns were not escalated to senior managers, nor did the social worker request advice from legal

[10] Published as 'Trauma Violence Abuse, 2007 Jul; 8(3): 270-280 and accessed on the 03.03.20 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3142744/)
[11] For example, https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-sexual-exploitation/
[12] A person commits rape if they intentionally have penetrative sex and the other person is under 13 [s5 Sexual Offences Act 2003]
[13] Taken for combined case notes submitted for the review

services regarding when child protection processes, including formal legal steps under the Public Law Outline, should be instigated.

2.7 Case records demonstrate that Kate's extended family also alerted the investigating police officer of their concerns that Kate was at risk from CD and notified police that, despite the confiscation of her phone, she had remained in contact with him through social media platforms. At the same time, her paternal uncle wrote to the strategic Director of CSC confirming that *'until very recently she was still in contact with a male third party who we strongly believe should be the subject of other police / other agency investigations. To what is extent is this contact with this person being monitored? She was recently travelling very early in the morning to an unknown destination before going onto school and this has caused us great concerns.* '[14] In response they were advised that information could not be shared without consent, but that as Kate had provide consent, the allocated social worker would be in touch. There is no evidence on the case records that this was followed up directly or used by the social worker to inform any risk assessment or investigation plan.

2.8 Research published by the NSPCC during this period warned against professional bias in respect of 'troubled children', of the unlikelihood that a young person would disclose sexual exploitation or abuse due to fear and/or loyalty to the perpetrator, lack of understanding they were being abused and lack of trust or fear of authorities. It also reported that '*too often, even when young people do disclose abuse, no actions are taken by agencies against perpetrators or to support young people and the abuse continues*.'[15]

2.9 The LADO commenced an investigation, obtaining the voluntary youth organisation's child protection policy and was advised by the allocated social worker that Kate had disclosed CD had placed a tracker on her phone so he knew where she was. A multi-agency meeting on the 20.12.13 was attended by the voluntary organisation, who agreed to consider suspending CD and his partner pending an investigation and, if this resulted in their dismissal, agreeing to make a referral to DBS in line with their legal obligations.[16]

2.10 Kate was discharged from hospital on 22.11.13 to her maternal aunt's care and continued to receive support from CAMHS, including a re-referral to the bereavement service, as well as liaison between that service, her GP and school nurse.[17] Kate reported feeling significant distress, she told staff supporting her that she continued to experience bullying at school, missed contact with friends from the youth group through which she had met CD and that her mother's drinking remained problematic. She was re-admitted for one night on the 17.12.13 due to suicidal ideation and self-harming (lacerations to her arm, abdomen and upper thigh) and reported to CAMHs staff she did this as she was angry that her aunt had disclosed that CD *"had forced himself on her and that police would be interviewing her on the new year*". CSC and CAMHs staff did discuss this further disclosure, but only in relation as to whether the police had been informed. Neither believed it had, yet neither considered notifying the police because '*social services were investigating*'.[18] This disclosure was also not passed to the LADO undertaking the investigation. Her aunt asked directly for information about the investigation into CD, but was advised to remain vigilant and to prioritise keeping Kate safe. This was a in

[14] Extract taken from letter provided by family
[15] Child sexual exploitation: learning from case reviews, NSPCC, November 2013
[16] The Safeguarding and Vulnerable Groups Act 2006 sets out the duty to refer (s35) and that failure to do so, without reasonable excuse, is a criminal offence (s38).
[17] A referral was also made to a specialist Sexual Trauma and Recovery Service, but was unsuccessful because she was in receipt of treatment from CAMHS.
[18] Taken from clinical notes

breach of the expected standards of enquiry and information sharing as set out in 'Working Together' guidance and the Council's local child protection policies.

2.11 By 2013 much was understood of the strategies used by adult perpetrators of child sexual abuse to target, isolate, groom and abuse children. Published case reviews had already urged practitioners to take into account the contextual circumstances and impact of neglect on children and young people which can make perpetrator strategies easier to carry out and more difficult to detect. Finkelhor's research had identified a four pre-conditions model of child sexual abuse[19] namely, that once a perpetrator is motivated to abuse (step 1) s/he must overcome internal inhibitions (step 2) and external constraints (step 3) to abuse and finally overcoming the child's own resistance to abuse (step 4). There is no evidence that practitioners working to investigate and support Kate at this time understood this model or suggested techniques to assist Kate, her wider family or the voluntary sector organisation's leaders to put in place effective strategies to frustrate this abuse.

2.12 On the 22.12.13 Kate contacted the police to complain she didn't feel safe with her aunt, who had confiscated a new mobile phone she had acquired. CSC and police later reported suspicions this had been provided to Kate by CD and police records report there '*were two text messages on it which appear to be* [Kate] *conspiring with another to provide a false explanation to cover any positive results of the forensic examination*.' Examination of her original mobile, provided evidence of contact conducted in '*veiled speech*' between CD and Kate, but police records record '*nothing of an obvious grooming/sexual nature*.'[20]

2.13 Kate's complaint prompted the investigating police officer to visit her on the 22.12.13 during which she was notified they '*could find no evidence to support the rape allegations*'. Kate retracted the allegations of rape, but confirmed during that meeting that she and CD remained in contact as she felt she could talk to him. Case notes simply report that Kate was advised not to have any more contact with CD, but no guidance was given to her or her extended family on the legal actions they could take to prevent contact. It also doesn't appear that Kate was told about any actions taken to investigate CD's behaviour.

2.14 Police records report that the LADO had confirmed that CD had acted in breach of the voluntary agency's child protection policy by allowing her to stay at his address and that he (and his partner) had been suspended pending further investigation. Police recorded continued concern that CD remained in contact with Kate via 'covert' phones he was suspected of providing. Kate's family were advised by the police to write to CD to ask him to stop contacting her and it was agreed this would be served on him by an officer from the Offender management unit. This was done early in 2014, at which time officers also 'unfriended' and blocked Kate's known number from CD and his wife's phone and advised they write to Kate's mother to request Kate did not make any contact. They were also advised to drop off any of Kate's belongings to the police station. Kate and her mother collected these and CD's letter to Kate later that week; they were again advised not to make contact.

2.15 On the 30.12.13 Kate and her aunt informed CAMHS staff that CD had threatened Kate that he would hurt her or destroy belongs left to her by her father, if she did not make the allegations to the police against her extended family. There is no evidence that CAMHs passed this information to police or CSC. Instead it appears it was left for Kate or her extended family to

[19] As detailed in 'Steps towards Prevention- ECSA toolkit' published by Lucy Faithful Foundation at: https://ecsa.lucyfaithfull.org/sites/default/files/attachments/Steps%20towards%20prevention.pdf
[20] Taken from police case notes

report to the police when Kate had clearly articulated having been in fear of him only a week beforehand.

2.16 In a home visit in early January Kate confirmed she was feeling 'a little better' now contact with CD had stopped and felt able to disclose CD's intimidating behaviour to her aunt. On 08.01.14 Kate's maternal aunt emailed the investigating officer, reporting Kate had confirmed to her that '[CD] *supplied the text for the two unpleasant emails you have been forwarded and that she copied them out because she is afraid of him and is scared that he will hurt her*.' She reiterated her fears that Kate continued to be controlled by him. In response the officer confirmed CD had been warned not to have contact and that the investigation was concluded as there were '*no tangible proof*' of a crime.[21] It should be noted that under the Protection from Harassment Act 1997 a person commits a criminal offence if they pursue a '*course of conduct that causes another to fear, on at least two occasions, violence will be used against them*'. Whilst a report by Kate's aunt could arguably have been considered as 'hearsay evidence' and may have been inadmissible within a criminal trial[22] this did not prevent the officer from carrying out further enquiries in response to new information. ACPO and CPS guidance[23] available to officers at the time, made clear special considerations should be given where disclosures may suggest a risk of child sexual abuse. Had this guidance been applied, this information should have triggered further investigation. Furthermore, there is no evidence within the case records that consideration was given by the police to applying or supporting Kate and her family to apply for civil orders to prevent future contact.

2.17 The criminal investigation was instead concluded as 'no crime' with a recommendation that Kate '*should be referred to ACT*[24] *for her over-sexualised thoughts*' and '*a referral was made to the YIT for wasting police time*.' This was subsequently recorded against the allegations made of '*rape against the football club chairman'*[25] It should be noted that Kate had never made an allegation of rape against the club chairman; she had only given information in respect of this when approached by the police, having been identified by another victim as someone who had also experienced a sexual contact offence in 2007/8. Subsequently the Youth Support Officer assigned the disposal raised a query as to whether Kate had been notified, as relevant paperwork hadn't been completed fully. Kate attended all YRI sessions, but was not aware (until conversations during this review) that this out of court disposal may remain on her police records.

2.18 According to relevant guidance[26] prosecution of an offence for wasting police time would need consent of the Director of Public Prosecution (usually delegated to a local Criminal Prosecution Service). In the circumstances of this case, it does not seem as if this would have been forthcoming as 'in the public interest' given Kate's circumstances and what was known about likely presentations by those subject to child sexual abuse at that time.

2.19 By mid-January 2014, Kate's aunts reported difficulties motivating her, maintain contact and managing behaviours because of who they suspected she was in contact with. Her mother had,

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[21] Extract from email exchange, dated 08.01.14.
[22] It should be noted that was not a decision for the police to make, this is determined by the Courts who may have considered it in the interest of justice for it to be admissible in line with S114(1) Criminal Justice Act 2003, guidance available at: https://www.cps.gov.uk/legal-guidance/hearsay
[23] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-abuse/ and https://www.cps.gov.uk/legal-guidance/child-sexual-abuse-guidelines-prosecuting-cases-child-sexual-abuse
[24] ACT possibly stands for 'Assessment Consultation Therapy'. As far as Kate is aware, she never receive this support. Any input at this time was purely in relation to the 'wasting police time'.
[25] Taken from police case notes
[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/354050/yjb-youth-cautions-police-YOTs.pdf, https://www.cps.gov.uk/legal-guidance/public-justice-offences-incorporating-charging-standard and https://www.cps.gov.uk/legal-guidance/child-sexual-abuse-guidelines-prosecuting-cases-child-sexual-abuse (see especially paragraph 57)

until this time, not yet engaged with services to reduce her alcohol dependency and it appears from the chronology as if very little had actually changed in Kate's life to reduce the risks posed to her welfare. Notwithstanding, CSC concluded their s47 investigation finding 'concerns substantiated' in respect of CD, but apart from notifying the LADO of these concerns and recommending that Kate's family decide whether they are 'happy' for her to continue to attend the youth group, no action was taken.

2.20 By Late January 2014 Kate was reported to be low in mood, withdrawn and asked her social worker if she could return to the youth organisation where she met CD. She also reported a breakdown in her relationship with her maternal aunt who, until then, had been a protective factor. The social worker's case records do not record any steps taken to assess risk that CD may seek to resume contact with Kate, nor was contact made with Kate's mother and wider family or the voluntary organisation to ascertain if CD was still suspended from the youth organisation. The social worker did not escalate or request legal or senior management advice on what steps could be taken and by whom to enable Kate to resume attendance safely or ensure that Kate's mother and CD understood he was to have no contact and the steps the local authority and police would take if he were to seek to do so. Kate was not given opportunities to disclose the abuse she had suffered, nor provided with assurance of any steps taken to prevent CD from contacting her. Records indicate no steps taken to ensure Kate understood the nature of the concerns regarding the risk of sexual abuse she faced. In short, Kate's voice was not heard and her rights under the UNCHR were not respected.

2.21 Had practitioners exercised professional curiosity and sought advice/ researched child sexual abuse they would likely have contextualise both Kate's and CD's behavioural patterns as indicating she continued to be at high risk of both neglect and sexual abuse. In conversations with the reviewer Kate was astonished that practitioners didn't recognise what was happening at that time. Whilst Kate may have differed in a number of ways from what was considered the 'normal profile' for someone at risk of sexual abuse, because (despite ongoing 'friendship issues' at school and crisis at home) Kate remained a good student; her attendance and achievements were notable. She also attended appointments with CAMHS and case records state she confirmed improvements in her mood, though she continued to clearly articulate her feelings that her mother was a 'bad parent'. Her remarkable resilience should not have been interpreted to diminish the risk of significant harm posed both by CD and her mother's ongoing neglect. It is clear from case records, her mother continued to minimise her role in providing a protective, safe environment and also undermined attempts made by extended family members to enforce boundaries to safeguard Kate.[27] Her mother attended some appointments to address her alcohol misuse, though case notes suggest very little progress was made to reduce her alcohol in-take or improve her ability to care. Case notes also evidence very little was done by practitioners involved with this family (and there were many by this time) to triangulate information as a means to assess the level of risk.

2.22 Practitioners did not seem aware of evidential standards which justify using legal powers to investigate child protection concerns. A 'reasonable cause to suspect' a child is at risk of significant harm justifies investigations under s.47Children Act 1989.[28] For police officers to

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[27] Mother also objected to Kate's paternal family being involved in a family group conference in 2014

[28] In *R (on application of S) v Swindon BC and Wiltshire CC* [2001] the High Court confirmed a local authority does not have to be satisfied on balance of probability that a person is an abuser before intervention is justified. '*What triggers the local authority's duty under s.47 is having reasonable cause to suspect, not reasonable cause to believe, which is the test in a number of other sections. Accordingly the threshold is quite low. This is hardly surprising as their obligation is to investigate i.e. make enquiries with a view to deciding whether to take any action to safeguard or promote the child's welfare. If the enquiries lead the local authority to the conclusion that action is necessary it is required by subsection (8) to take it*.' [pg36] In addition, the courts have repeatedly recognised that the interests of persons

exercise their powers of arrest they must have reasonable grounds to suspect an offence has been committed, that the arrested person has committed it and that it is necessary to arrest the person.[29] Clearly, it may be possible to carry out an investigation without using powers of arrest, however, once that threshold is crossed officers can proactively searched for evidence. In this case, Kate's risk of significant harm had been substantiate and, a forensic examination had '*not rule out the possibility of sexual assault having occurred',*[30] there were allegations he had threatened her, tracked her movements and compelled her to make false allegations against family members. All of this should have sufficed to justify interviewing him under caution (e.g. for breaches of the Protection from Harassment Act 1997). It should also have lead on to consideration of other remedies open to the police (e.g. Child Abduction Warning Notice).[31]

Finding: The investigation in 2013 into grooming and abuse by CD was not sufficiently robust given what was known of the likely presentations at the time. Information was not shared appropriately between agencies or with Kate and her wider family, despite the significant role they were given to act in a protective capacity. Insufficient weight was given to the voice of the child and concerns raised by her family members. Too much reliance was placed on family members to impose restrictions on Kate, whilst actions to secure collaborative evidence (e.g. by interviewing CD or even re-interviewing Kate) were not taken.

The decision to refer Kate for a Youth Intervention for wasting police time was not consistent with national guidance in force at the time.

3. **How robust was the Child Protection process, including whilst Kate was subject to a Child Protection Plan and Missing and Exploited Children's Conference, in identifying and addressing the risk of emotional and physical safety and sexual exploitation?**

3.1 The completion (on 13.03.14) of the s47 investigation recommended an initial child protection conference; this was held on 02.04.14 and concluded Kate was at risk of significant harm of neglect. The meeting noted the impact on Kate of her role as a carer for mother and referenced concerns regarding 'inappropriate behaviour' between a youth group leader and Kate and her knowledge of adult issues but didn't specify risk of sexual harm or name the source of risk. Again, the protection plan centres on a referral for bereavement services and for her School nurse to undertake a health assessment. No actions were identified to address the risk posed by the ongoing neglect, her mother's unwillingness to allow extended family members to support Kate or to address risk of sexual grooming. No actions were listed to monitor CD's contact with Kate. A review of the combined case records suggests drift during this period, e.g. the referral for support as a young carer still hadn't been actioned at 22.07.14 and, whilst Kate was still requesting permission to be allowed to return to the youth group, a decision on this was indefinitely deferred. Despite clear evidence of a lack of engagement from Kate's mother to the plan[32] and Kate reporting concerns regarding her mother's new partner, CAMHS conclude her mental wellbeing was stable and suicidal ideation has decreased so input could become less frequent. The withdrawal of therapeutic support didn't prompt a re-evaluation by CSC as to

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in a similar position to CD come second to the interests of children at risk of harm. The local authorities' assessments and actions are of a nature where a wide margin of appreciation has to be given to the interpretation of the right to privacy and family life protected under Article 8 ECHR: *R v DPP ex parte Kebiline* [2000] 2AC 326. It should also be borne in mind that the European Court has held that in a conflict between the rights of a child and of parents, the rights of the child should prevail. *Hendricks v Netherlands* (ECHR) 1983.

[29] e.g. because it is necessary to protect a child or other vulnerable person from the person in question[pg2.9d] or to allow the prompt and effective investigation [pg2.9e- Code G, PACE Code of Practice for Police Officers.]

[30] The forensic examination confirmed only there was no evidence of the brutal nature of the attack she had alleged, not that there was no evidence of sexual activity. Given her age at that time (12) this would have justified an investigation under s5 Sexual Offences Act 2003.

[31] More detailed available at: http://library.college.police.uk/docs/appref/CAWN_Procedures_final_v1.0_240919.pdf

[32] Case records indicate no sustained change in mother's alcohol use and she also cancelled a number of key appointments over several months.

whether Kate might need additional input to maintain or even improve her wellbeing. Kate, during conversations with the reviewer, understood that practitioners may have to balance taking action to address concerns raised by wider family members against building a relationship of trust with a child, but felt that in her case very little was done by the allocated worker to engage with her. She feels now the worker used this as an excuse and instead should've acted to address the legitimate concerns raised by her wider family. She couldn't remember her allocated worker making any attempts to speak to her about the risk of sexual abuse or any advice/ discussions regarding sexual safety. She expressed regret that she hadn't asked for a new worker but felt she wouldn't have known she could question decisions made about her at the time. She feels, understandably, angry that her wider family were side-lined by professionals.

3.2 In July 14 Kate was admitted to hospital with a suspected sexually transmitted disease. Hospital staff, concerned she may not be safe to go home, originally agreed to admit Kate but following confirmation from CSC they will progress safeguarding concerns (though case records did not say how), agreed to discharge. There is no record that Kate or her mother were involved in any decision making or that Kate was spoken to alone. The opportunity was not taken to enquire safely whether she was sexually active and thereby explore if she was being sexually abused.

3.3 A Child Protection Review Case Conference was held on the 4th July 2014. It does not appear that Kate was in attendance and there is no evidence she was spoken to before the conference. It was reported '*Mother has continued to engage with support services and school reports that* [Kate's] *mood has improved*.' The school nurse's records confirmed outstanding actions from plan included '*Children's Services have not been able to complete "keeping safe" work and results not yet received from hospital about sexual health screen'*.[33] Working together guidance advised the purpose of the review was to consider whether Kate continued to suffer significant harm and to review progress against the protection plan outcomes. This required social workers and their managers to share conference material within the child and family beforehand, provide information and decide whether to initiate family court proceedings. According to the statutory guidance, discontinuing the protection plan should only occur if it is judged the child is no longer continuing or likely to suffer significant harm. Despite very little having changed for Kate, outstanding key actions within the initial plan and fresh concerns that warranted investigation into whether Kate continued to be exposed to sexual abuse, the Conference chair overruled the majority and removed Kate from Child Protection Plan. Instead a Team around the Family ['TAF'] was to support her. The school nurse formally dissented to this decision and she was informed that the Conference Chair would take the case to the Safeguarding Board dissent group. It is understood that a report was submitted, but that this was not acted on. At the first TAF meeting (held on 22.07.14) CSC cease their involvement. The internal auditor involved in this review concluded this decision for 'TAF' was '*not consistent with local step-down processes and effectively meant that Kate was closed to Children's Services.* [The Conference Chair] *failed to consider lack of engagement by mother in March 2014 which stepped the matter up to Strategy Discussion and ICPC or recent and historical information in relation to mother's use of alcohol*.'[34]

3.4 In 2014 OFSTED reported that the Council's '*practice of stepping down cases to universal and targeted services has led to the authority failing to provide a range and level of services to safeguard and promote children's and young people's welfare. A significant number of children*

[33] Taken from the combined chronology completed for the review
[34] Taken from the combined chronology completed for the review

in need are not receiving the level of support and monitoring necessary to ensure their welfare and protection.'[35]

3.5 The next TAF meeting (held on 12.09.14) confirmed that Kate's mother rarely attended appointments with alcohol services and whilst she reported improvements in her alcohol use, it was noted she smelled of alcohol at the meeting. Kate's mother was advised she would not be eligible for mental health support (to address anxiety) due to her alcohol in-take. There is no consideration as to how this could impact on her ability to provide basic care or protection to Kate and no interventions put in place to support Kate. By November 2014 Kate's mother had not attended any appointments and admitted she was drinking daily. Kate also disclosed to the School nurse her mother was drinking more than she was telling professionals, she explained she was unhappy she couldn't attend the youth group, and no-one has explained why and that her mother didn't want to spend any time with her. Again, despite clear indications that Kate was an isolated child, neglected by her mother and with actions to address the risk of sexual abuse still outstanding, still nothing was done to escalate this to the level of support that would have been required in accordance with National guidance or the Local Authority's own local child protection policies.

3.6 In December 2014 the CAMHS clinical team meeting records identified that Kate had been groomed by a youth group officer, re-iterating earlier disclosures that '*a letter was dictated by the predator, accusing her family of abusive behaviour, he threatened to harm her if she did not write the letter*'. It does not appear the practitioner was advised by senior staff of their duty to share this information with the police or CSC despite clear statutory guideline[36] to do so. There is no evidence that this information was used to inform a review of the risk assessment or action plan to address the perpetrators behaviour, instead CAMHS care plan focused exclusively on improving Kate's relationship with her mother. Given the longevity and significant nature of neglect Kate had experienced by this time, Kate confirmed to the reviewer that, even at the time the focus of this input seemed wrong. She reported she felt the professional showed little empathy and she only ever remembered being asked 'how does that make you feel?' Kate explained it was crucial that any learning review understood the impact that her mother's neglect, even if not intentionally malicious, had on enabling the sexual abuse to continue. She explained her mother remained oblivious to the harm she was experiencing. She remembered her mother asking her for money to buy beer and also feeling so isolated because her mother had blocked contact with her paternal family and turned her maternal aunt against her.

3.7 By Jan 2015, during a joint meeting with CAMHS, both Kate and her mother confirm they had disengaged with Kate's paternal family and expressed fears regarding the high risk that Kate may self-harm or be harmed by 'others'. Who posed this risk was not explored, nor is there any consideration regarding the gap left in the initial protection plan if Kate's wider family were no longer involved. The risks were not shared with other TAF professionals.

3.8 Later that month, Kate's mother disclosed Kate was pregnant to her CAMHS worker. This information was shared with the school who referred this to CSC. Kate's GP later confirmed to the TAF she was not pregnant, so no further action was taken to discuss this with Kate. Kate was only aware that practitioners were told of her pregnancy as a result of the conversation with the reviewer. She confirmed the pregnancy was a result of the sexual abuse. She explained that she suffered a miscarriage. At the time, she had gone to her abuser's home for help and they had called '111' for advice, though not disclosing her name. She remembered being asked by him to

[35] Inspection of services for children in need of help and protection, children looked after and care leavers Inspection date: 21 October 2014 – 12 November 2014 Report published: 3 June 2015, Available at: https://reports.ofsted.gov.uk/provider/44/80567

[36] Working Together, 2013

leave and, despite being in excruciating pain, had done so because he was concerned his partner would come home. She spoke of her fear and of crouching in agony behind the bins near her home whilst she lost the child. This was clearly extremely traumatic for Kate and, for her, formed a major part of the abuse. She explained that if at that time, '*just one person I trusted had taken the time to sit with me and ask, it might have taken a while, but I would have told them*'.

3.9 Efforts were made by Kate's extended family to escalate their continued concerns and by her school to escalate this to CSC. Case records indicate that the school notified CSC that her mother cancelled the TAF meeting because Kate '*thought she was pregnant*'. CSC recorded the outcome of this referral as '*NFA letter to be sent to mother advising her to engage with TAF*'.[37] A few days later CSC received notification through the NSPCC seemingly reporting Kate's maternal family's concerns that Kate was in a '*secret relationship with an older man called* [CD]' The referral set out the history of the earlier investigation, and new information including that '*in December we found out that ['Kate'] became pregnant by her older boyfriend and we found love cards hidden in her draw signed by* [CD] *which said in them about being together and starting a family when she is old enough and a keyring of the pair of them cuddling together at Hyde park's winter wonderland.* …[Kate's mother] *and* CD *have now become friends and we have been informed that CD is going to be lodging with her as she is off work with depression and needs a lodger to keep up with her mortgage payments*'.

3.10 It appears from case records that a status of 'anonymous and unconfirmed' concerns was attributed to the information contained within the NSPCC referral, though it should have been very clear with only cursory review of CSC case records that this had come from a member of the extended family. Had CSC carried out even a very brief enquiry with professionals involved in the family, they would have been able to confirm which family member; Kate's aunt had tried to notify professionals that week of the ongoing abuse. No enquiries were conducted, nor was the matter escalated, instead CSC requested the school nurse organise a TAF meeting and invite the social worker to this.

3.11 In conversations with the reviewer, Kate's extended family spoke of their hopelessness at the lack of response they received from the concerns they raised. They felt there had clearly articulated the level and nature of the abuse Kate was facing from CD. They had also explained her mother's inability to monitor CD's contact with Kate and their fears that because of the very clear parental neglect she was experiencing, Kate was unprotected. They stressed that it was not easy for them to raise their concerns, as this meant openly criticising Kate's mother which felt like a betrayal. They explained that, at the time, they themselves couldn't cope with the overreliance statutory services placed on them to manage the risk that her mother's neglect and his abuse posed. They are understandably angry that such little weight was given to the information they disclosed. They explained that child protection practitioners should take into account how hard it is for families to overcome natural familial affiliations to share concerns with professionals and take those concerns seriously. They were also exasperated that, whilst they were often used by professionals to provide protective care, they were then ignored when they raised concerns about Kate's ongoing safety. Kate's family felt it was too easy for different agencies to dismiss their concerns and deflect back to Kate's mother without proper consideration of her ability to understand and act to protect Kate from the ongoing abuse.

3.12 The NSPCC also referred their concerns to the police and LADO service. The initial police officer responding recognised the need to follow the 'CSE workflow' referring for a strategy discussion at the Multi-Agency Safeguarding Hub ['MASH']. They also recorded the need to consider available remedies even if the child did not engage. However, a MASH assistant later

[37] Taken from the combined chronology completed for the review

recorded they had '*discussed the anonymous referral with the LADO and Children's Services who had contradictory information as* Kate *and her mother had been subject to TAF for some time. The LADO stated that children's social care had 'called'* Kate's *mother who had told them that she was facilitating contact between CD & Kate and she is clear that there is no sexual contact. Mother did think that* Kate *was pregnant but this was with a boy at school – a home pregnancy test was positive but a second test was negative*.' Officers carried out a home visit, though Kate was not seen alone. Kate's mother confirmed to the police that CD was in contact and was helping her with her mortgage. The case records state '*officers checked flat for evidence of a male lodger, which proved negative… no suggestion Kate being sexually exploited*'. Kate's mother later the same day confirmed her sister had made the report and requested she be charged.[38] Shortly afterwards the LADO contacted the youth organisation and was advised that CD had been reinstated and that Kate has returned to the group after they had received written notification from her mother that she had withdrawn the 'no contact' agreement. The earlier decision by CSC to have no further involvement in the case appears to have been a significant factor within the youth organisation's assessment there was no risk regarding CD's conduct and on-going contact with Kate.

3.13 There appears to be an assumption that, because there are a number of professionals involved within the family and the length of time concerns had been known to services, the likelihood of the abuse continuing was low. It is hard to see how professionals could have formed this view. Statutory expectations regarding investigations and information sharing had not been met and there is no evidence that professionals had approached their functions with a sufficient degree of investigative enquiry or professional curiosity. There is also a distinct lack of awareness by professionals of their legal obligations and duties under the UNCRC and Human Rights Act to protect Kate.

3.14 The LADO requested CSC undertake an assessment; specifying this was to include CSE risk assessment and regular liaison with the LADO. On 20.02.15 a social worker was allocated. However, she didn't attend the TAF meeting on the 26.02.15 and Kate and her mother confirm they'd had no contact. Eventually the family support worker, not the allocated social worker, decided to call a strategy meeting concerned that Kate had disclosed her mother was drinking 14-15 cans a day and gambling heavily. The case records report Kate feeling '*under pressure and unhappy'*. Before the strategy discussion took place, further concerns were raised by the youth organisation regarding CD to the LADO. In early March Kate was admitted into hospital following a further overdose; the fifth requiring hospitalisation in 18 months. A request was made by the ward to CAMHS for a joint assessment so that post discharge care arrangements could be agreed, but it does not appear CSC were notified.

3.15 The strategy discussion finally took place on the 20.03.15 between CSC, police, LADO and 'paediatric liaison'. Despite her central role as lead professional until this point, it does not appear the school nurse was invited. Kate expressed incredulity when discussing this with the reviewer and highlighted that, by this time, the only person she had any real contact with was the school nurse. Again, the central focus of this meeting seems to be how difficult it may be to prove there is an ongoing 'inappropriate relationship'. It was decided to start a further investigation under s47 Children Act 1989. There was no consideration to whether the police or local authority should seek legal advice to ascertain legal options to keep Kate safe. Given the serious longevity of the neglect, the numerous indications providing reasonable cause to suspect sexual abuse and Kate's mother's apparent collusion with the perpetrator (even if this was a result of grooming on her), this seems remarkable. A representative from the Council's legal

[38] Taken from the combined chronology completed for the review

services did confirm that, had a request been made at the time for a Legal Planning Meeting, it would have likely resulted in formal legal processes under the Public Law Outline.[39] Kate commented to the reviewer that, throughout this time she was telling her abuser that CSC were investigating the abuse, but he would reply 'no-one has spoken to me' and it was clear to her at the time this gave him confidence that he was safe to continue the abuse.

3.16 The LADO also subsequently met with the leaders of the youth organisation, the case records available suggest both appear unsure of their legal grounds for progressing a fresh enquiry; they agreed to seek more information from the police regarding the earlier police investigation in 2013 and review at the next strategy discussion. Notes from that meeting contain factual inaccuracies (e.g. Kate had not 'self-harmed since 2013'). Discussions identified issues that remained live concerns and note that extended family members' fears and their alienation '*could make* Kate *and her mother more isolated and potentially more reliant on CD'*, but again without reference to legal advice, professionals decide no further action can be taken as concerns were '*more allegations and suspicions than facts*'.[40] The LADO is tasked with '*undertaking some safeguarding work*' with the youth organisation.

3.17 A few days later a further assessment was arranged between CAMHS and ward staff after Kate attended having taken a further overdose triggered by bullying at school (she had received sexual images on her phone). Kate told staff she '*wants help, scared about school the next day… Felt ignored by mum when she went home, that she was invisible and no one cared' She disclosed again the extent of her mother's drinking, her fear that she might fall and hurt herself and she would lose her too, that she had to clean as mum can't, mum has mood swings, shouts at her for no reason*.' Nursing staff note mother's speech is slurred, they recognised '*risk to self at time of assessment is low, potential for further DSH high*.'[41] They also record continued concern raised by Kate's aunt regarding contact with CD but discharge Kate to her mother's care with no clear follow up plan and no contact with CSC.

3.18 By May 2015 Kate's mother had notified alcohol support services she wouldn't attend further appointments (claiming anxiety at travelling) and that IAPT sessions and the TAF had stopped. Kate's school attendance was of significant concern (77%) to justify referring to an Education Welfare Officer. If this was passed to CSC it did not factor into the decision making that her case did not meet the criteria for child protection despite ongoing '*professional concerns and suspicion that CD has been inappropriate with* Kate *whilst in a position of trust … There continues to be concerns around* Kate's *mother's parenting capacity in light of long-standing alcohol misuse and mental health. If there are clear concerns, then we need to consider the appropriateness of YSS (Youth Support Service) to undertake some direct work with Kate and complete a CSE risk assessment if appropriate.'* Kate's case was instead referred to the Missing and Exploited Children's Conference ['MAECC']. This was set up to monitor medium and high-risk cases of child sexual exploitation.

3.19 CD had tendered his resignation from the youth organisation on 19.April 2015 but was suspended on the 13.05.15. Shortly afterwards (18.05.15) the building where the group met was burnt down. The fire was set deliberately and started where the organisation stored belongings. The organisation's leader confirmed to the police CD had recently carried out a fire pre-inspection and commented if there was a fire, they would lose everything. This is potentially relevant as an indication of how confident he had become that he could act with impunity.

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[39]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306282/Statutory_guidance_on_court_orders_and_pre-proceedings.pdf
[40] Taken from the combined chronology completed for the review
[41] Taken from the combined chronology completed for the review, DSH assumed to mean 'deliberate self-harm'.

Despite having been suspended, he was not referred to the DBS services as the organisation had '*difficulty contacting CD following his suspension and had not been able to contact Kate to further their investigation*.' They were initially challenged by the LADO to confirm whether they would have dismissed him on the information they had if he hadn't tendered his resignation. They confirmed in October 2015 they would normally allow past volunteers to return to activities. The organisation was only subsequently contacted again by the LADO in February 2016 for confirmation as to the decision to report to the DBS. There is some evidence that the LADO was aware of her own duties (to report CD) might be triggered by the level of concerns, but when the organisation did not respond this was not pursued or escalated. The trustees/ leaders of the organisation were not offered guidance on their legal duties to complete this action or face criminal sanction. Police records indicate their enquiries into the fire had shown that, prior to and after the fire, CD had been in phone contact with Kate '*contrary to the written agreements served on CD & Kate*' but again no further action was taken by the police to investigate this further. In fact, it was widely understood that he was by this time living with Kate and her mother.

3.20 At the first MEACC meeting in June the police were tasked with finding out more information on previous investigations, suggesting that very little of the history and nature of concerns were included within the referral. It does not appear they were aware of the ongoing investigation into the fire. There was no police representative at the following meeting in late June, so this was not progressed and by the third meeting (July 2015) it was noted Kate and her mother were re-locating to the North of England; it was believed this was to '*lose professionals*'. An instruction was given that CSC will share information '*in regard to the risk of grooming in this case'*.[42] No deadline was given or named person allocated to undertake this action. By the subsequent meeting in August 2015 this remained outstanding. Police records report an email was sent to the relevant constabulary in the North of England from the MASH '*detailing the CSE risk to Kate from CD having relocated to the North of England*.' So, presumably, it was understood by senior staff within the MAECC he had moved and was living with Kate. A review by the SAB in the North of England explored what information was shared by professionals and noted a failure by CSC to provide a copy of the most recent assessment or child in need plan. It also noted the school records did not include their safeguarding file. In addition, whilst only partial records were received by the school nursing service, sufficient information was received regarding her mother's inability to protect, her father's death, a previous overdose, the alleged rapes and concerns regarding grooming that warranted further enquiries which were not undertaken.

3.21 Practitioners involved in this review acknowledged the response to recognised risks in this case was wholly inadequate. This accords with OFSTED's evaluation of the service in October 2014,[43] which rated the service as inadequate. A key part of the inadequate rating was in respect of children at risk of sexual exploitation and abuse. Inspectors identified '*in 13 of the 17 cases seen which related to risk associated with child sexual exploitation, children did not benefit from a co-ordinated response, and alerts to risk factors were not being fully identified or responded to effectively. Of the 45 team around the family (TAF) cases sampled on this inspection, 17 were found to have been inappropriately stepped down to TAF arrangements. Cases where there is potential risk to children living in neglectful households, or where there is ongoing domestic abuse, parental mental ill-health or substance misuse, are not being effectively managed and these children are not receiving the right level of support. The early help model of intervention does not provide a framework for systematically tracking and monitoring cases stepped down to*

[42] Taken from the MEACC minutes supplied to the review.
[43] OFSTED report, inspection date 21.10.14-12.11.14, published 03.06.15 available on: https://files.ofsted.gov.uk/v1/file/50004296

TAF, and the outcome of interventions for these children is not known.'[44] Whilst the OFSTED report wasn't published until June 2015 those involved with the MAECC would likely have been made aware of key concerns beforehand, including that OFSTED had been highly critical that high risk cases (such that they required MAECC risk assessment) were often inappropriately managed, in that any protection plan was expected to be implemented by universal and youth services, finding that this meant '*children were therefore not benefiting from statutory intervention and suitable social work support*.'[45]

3.22 In the report of the Inspection of services for children in need of help and protection, children looked after and care leavers in 2014, published in June 2015, OFSTED recommended:

- a review of all cases where children have been identified as at risk of child sexual exploitation and ensure services are in place to minimise risk and provide effective support. [REC 3]
- Ensure that professionals, including partners, who work with children who may be at risk of child sexual exploitation have the necessary skills to recognise risk factors and to act effectively on alerts to risk [REC 12]
- Improve the arrangements for joint working in the identification, collation and analysis of performance information relating to children missing from care and home and at risk of child sexual exploitation, so that the local authority can effectively use information across the partnership to drive improvement. [REC 23]

By August 2015 a follow up OFSTED inspection report[46] identified continuing issues with local guidance on thresholds for accessing statutory social work services, as well as leadership and scrutiny of practice for protecting those at risk of sexual exploitation. Senior representatives reported to the reviewer that in 2015 the MAECC processes were underdeveloped. Despite OFSTED's recommendations, there is no evidence that action was taken to review Kate's case records and ensure the receiving local authority had all the appropriate information to evaluate the risk posed to Kate by both her mother's neglect and by continued unsupervised contact with her abuser.

3.22 During conversations with the reviewer Kate confirmed that both before and after the move to the North of England CD effectively controlled her every moment. He had cut her off from friends and family, including stopping access to the internet. She spoke about increasing levels of violence he used and of him forcing her to do all domestic tasks (cleaning, ironing, cooking and walking the dog). Kate explained that, at the time she felt powerless; it seemed to her so easy for him to do whatever he wanted as he was always one-step ahead of the authorities. Shortly after the move, her mother moved out of the home leaving her completely unprotected. Kate confirmed that the abuse continued until, in response to an emergency call in June 2017, a police officer seemingly recognising the signs of abuse told her '*we know what this is*'. She said she had been trying to tell people for so long, that this was all she needed.

Finding: Practitioners were aware of the potential risk indicators of sexual abuse and recognised how her mother's neglect and Kate's isolation increased this risk. Their response to the identified concerns was wholly inadequate. Despite a high number of professionals and all key agencies having been informed of the risk, coordination was severely lacking. Information was not gathered in a way that facilitated effective shared risk assessment or managed to reduce or prevent abuse. There were too many handovers with little or no follow up to ensure that those receiving referrals had the information or skills to support Kate. As reported by OFSTED, child protection services did not meet

[44] OFSTED 2014 Inspection of services for children in need of help and protection, children looked after and care leavers report, p. 48
[45] OFSTED 2014 Inspection of services for children in need of help and protection, children looked after and care leavers report, p. 57
[46] Available at: https://files.ofsted.gov.uk/v1/file/50004302

expected standards within national statutory guidance. As a consequence, no consideration was given to securing legal advice and instigating child protection proceedings despite long-standing, significant risk of harm having been substantiated by the s47 investigations.

The LADO and voluntary sector organisation did not fulfil their legal obligation by thoroughly investigating the allegations against CD, nor did they report concerns to the DBS.

4. What is needed to improve future practice and ensure effective inventions to protect young people at risk from people in positions of trust?

4.1 In his 2003 report into the death of Victoria Climbié, Lord Laming[47] stated:

> *"I recognise that those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task...Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the well-being of a child."*

4.2 Alnock[48] highlights many of the strategies used by adult perpetrators of child sexual abuse to target, isolate, groom and abuse children coupled with the contextual circumstances and impact of neglect on young people can make perpetrator strategies more difficult to detect.

4.3 Kate and her family spoke of the powerlessness they felt in the face of CD's ability to manipulate professionals and deflect attention from the abuse he was inflicting. Throughout Kate's case records, practitioners used terminology which at best deflected attention, at worst could be seen as 'victim blaming'. Kate's distress and self-harming was referred to as 'attention seeking'[49], reports that she had been raped, was pregnant or had contracted an sexually transmitted disease were not investigated. Throughout the case records there are numerous examples where Kate's or her family's disclosures are given little weight because they are reported by a third party (NSPCC or usually a trusted family member) or are simply not passed to CSC, LADO or the police. This suggests practitioners were unaware of their role in providing corrobative evidence. Kate's experience supports research findings which identified that even if there is evidence that a child is being abused, some practitioners, or the institutions within which they work, will remain 'wilfully ignorant' and turn a blind eye to the abuse.[50]

4.4 It is also important to acknowledged that practitioners from different disciplines and agencies have their own specific, separate focus and that this can sometimes mean that there isn't a common language or shared understanding of risk, which in turn can be exploited by perpetrators of abuse. Multi-agency protocols and services should seek to establish systems which actively impede sexual abuse, taking into account Finkelhor's four pre-conditions model of child sexual abuse. This requires a whole systems approach with careful use of language and clarity on agencies responsibilities and legal powers to ensure partners work in a coordinated way. Existing legal and policy frameworks if properly understood could enable parents, wider family members and practitioners put in place effective strategies to secure early identification of abuse and a focused multi-agency response to disrupt and prosecute adult perpetrators. Policies and risk management processes must also highlight the importance of ensuring the voice of the child is central to

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[47] Victoria Climbié Inquiry, the Lord Laming Report, 2003:3

[48] 'Exploring relationship between neglect and adult-perpetrated intra-familial child sexual abuse', Debra Allnock, available at: https://www.nspcc.org.uk/globalassets/documents/research-reports/neglect-intrafamilial-child-sexual-abuse-evidence-scope-2.pdf

[49] E.g. within referrals for CAMHS support [15.07.13]

[50] University of Bedfordshire (2015) Child sexual exploitation: a social model of consent. Available at: http://youtu.be/1oyE-qE4340 (Accessed 05.02.20).

every decision, including a decision not to act and that practitioners explain within the multi-agency context, their rationale for decisions so that wherever necessary this encourages accountability and critical challenge.

4.5 **The role of LSCP and strategic leadership within child protection agencies:** OFSTED continued to express concerns in September 2018 that '*cyclical 'start again' social work is compounded by a complex service structure, requiring numerous handover points and changes of social worker as children travel through the statutory social work system… Many social workers, frontline managers, child protection conference chairs and partner agencies have insufficient knowledge and understanding of the impact of cumulative neglect, exposure to domestic abuse and other adult difficulties on children*….[such that use of the PLO pre-proceedings work] *on the accumulative evidence of continuing harm and neglect to children is the exception rather than established practice*.' This accords with Kate's experience and her comment that it was hard to establish relationships of trust when there was so many changes to personnel involved in her case. The complexity of the social work system made it difficult (even for the reviewer) to clearly establish which practitioner or agency was expected to lead on collating information on risk.

4.6 In September 2018, following a monitoring visit, OFSTED commented that not enough effort is made to engage men[51], particularly those who have not been convicted, in perpetrator programmes or to consider their offending histories with the police and probation services, in order to inform risk assessments of their potential to further harm children. Senior representatives supporting this review recognised how practitioners investigating this case did very little to challenge her abuser's behaviours, despite clear instructions that he had acted in breach of the youth organisation's safeguarding policy and had breach the no-contact agreement. Details of possible legal orders are set out within the LSCP's multi-agency policy.[52] Whilst in prison and despite restrictive orders, CD has made attempts to intimidate Kate. The likely continued risk he poses on his release from prison was understood at the time of his conviction (necessitating further orders and conditions). Consideration will be needed before his release to what support she will need to stay safe and, if she chooses, to have input into the parole process. The LSCP may also wish to explore whether child protection practitioners can access advice from agencies with expertise in the management of offending behaviours on possible risk reduction measures they can lawfully employ as part of a plan and when failure to comply with any protective measures would indicate reasonable grounds to believe a child may be experiencing significant harm.

4.7 In January 2019 OFSTED noted '*Senior managers' attempts to escalate police responses encountered resistance*. *While it is essential that risks of adult exploitation and other dangers encountered by children who go missing are regularly reviewed by senior managers from partnership agencies, it is also vital that all available civil and legal avenues are used to protect children and help them to escape exploitative adults and networks. Efforts to disrupt, pursue and prosecute alleged perpetrators are not always assertive enough*.'[53] Again, Kate's case demonstrated how a lack of knowledge between professionals of the possible legal orders and processes available to safeguard her, meant even when there was clear dissent from practitioners (e.g. the decision to remove Kate from child protection plan) it proved impossible for practitioners to provide effective challenge.

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[51] Monitoring visit of Surrey local authority children's services, published October 2018, p. 3

[52] https://surreyscb.procedures.org.uk/hkpol/procedures-for-specific-circumstances/working-with-sexually-active-young-people

[53] Monitoring visit of Surrey local authority children's services, letter dated 25th January 2019, p. 3
https://files.ofsted.gov.uk/v1/file/50056033

4.8 Within the multi-agency procedures (dated 2017) there is advice on how practitioners should respond to risks of sexual abuse and information on the legal framework applicable to children who are sexually active. Consideration could be given to reviewing these sections to ensure an explicit reference to the underlying purpose and legal duty to consider the voice of the child and the responsibilities for parents/carers to keep a child safe. Language used must avoid victim blaming, minimising risk or deflecting attention from perpetrators. It should also incorporate the new risk guidance and toolkit. All guidance should make clearer the link between identifying a risk of significant harm and the legislative thresholds that trigger professional duties to investigate where there is a reasonable cause to suspect criminal behaviours, or a child might be at risk of significant harm, or a person in position of trust might pose a risk. Guidance should also include the role of Legal Services and clarify when and how child protection concerns should be escalated, in line with the Public Law Outline and s31 Children Act 1989. The LSCP should consider offering guidance that where there is reasonable cause to suspect a child is at risk of sexual abuse or exploitation, this is recorded as the principle category of risk on child protection plans and other types of abuse are carefully considered against Finkelhor's four pre-conditions model so that CP plans and contingency plans adequately reduce the risk through early detection or disruption.

4.9 It is noted that in the letter following the monitoring visit of 31st October 2019 to 1st November 2019 (published in December 2019) OFSTED recognised '*a more committed, strategic response to child sexual exploitation has led to additional strategic partnership posts, increased awareness raising and a new risk management process to replace an earlier model that was not wholly effective in assessing and reviewing risk. Older children who are at risk of or who are experiencing child exploitation are quickly assessed and engaged by social workers, family support and targeted youth support workers. Useful information provided by children in return home conversations is immediately passed to specialist police officers, who use it to undertake intelligence mapping, disruption and dispersal activity. Senior managers recognise that assertive, persistent outreach work with children who are at acute risk needs to evolve and improve further, and they have realistic plans to build on the current constructive direct work carried out.'*[54] But warned '*regular multi-agency risk management meetings review and oversee risk reduction work with those children who are at the greatest risk, but the information and intelligence from these meetings is not always easily discernible in social work case records and intervention plans… There is limited evidence, however, of reflective, curious questioning evaluating how the cumulative impact of busy multi-agency interventions are improving children's lives, and scant evidence that managers are advising social workers about how they should approach their direct work*.'[55]

4.10 Currently, the LSCP offers a training programme for partner agencies to support the early identification of sexual abuse and exploitation. It receives assurance through a data dashboard to enable oversight of case management of child exploitation work. There is also a multi-agency service response proposal[56] detailing the expectations for support and disruption and local service guide.[57] In September 2019 a new toolkit and guidance was introduced for partners. This advises of the importance of promoting positive relationships with family, friends and carers, communities and of gathering corroborative evidence to prevent overreliance on the child to report abuse. It requires a referral to CSC if there is a vulnerable child at significant risk or experiencing sexual exploitation. The risk assessment

[54] Monitoring visit of Surrey children's services, published December 2019, https://files.ofsted.gov.uk/v1/file/50134643
[55] Re-inspection of services for children in need of help and protection, children looked after and care leavers, paragraph 98, published 16th May 2018
[56] https://www.surreyscp.org.uk/wp-content/uploads/2017/07/CSE-MA-Response-diagram.pdf
[57] https://www.surreyscp.org.uk/wp-content/uploads/2019/06/Child-Exploitation-Prevent-Prepare-Protect-Pursue-service-guide.pdf

tool does not, however, identify what action should be taken by those completing the tool (e.g. practitioners in universal services) if they have identified an emerging risk (i.e. a vulnerable child with one or two indicators of sexual abuse/ exploitation present). Again, partners may wish to revise this to ensure staff working in universal services understand emerging risks may trigger duties to investigate and ensure there is an established pathway so that the child, their parent/ carer and potential perpetrators can access existing preventative or early intervention support.

4.11 **Child protection practitioners:** Since 2017 CSC staff training has been prioritised around child sexual exploitation, 'Total Respect' and the implementation of a recognised strength-based model of social work practice.[58] A service re-design with CSC has also reduced caseloads, but there remains continued concern the '*views of children are captured, but, frequently, are not used to produce a clear picture of their lives at home, and the degree of continuing risk they may be exposed to. The practice of documenting risks, strengths and worries in columns, and the prevalent use of scaling exercises, can sometimes overcrowd and obscure, rather than illuminate, children's core risks and needs. Conference chairs do not always document their analysis and evaluation of risk crisply and clearly, and this indicates a lack of rigour in their expert decision-making responsibilities. Plans often feature numerous actions that are not prioritised to help parents and professionals work on the most important elements in a sequential way… Some plans are too lengthy and are saturated with dense professional language*'[59]

4.12 In Kate's case, practitioners from across specialist child protection teams didn't consider relevant statutory guidance within their decisions. This was most stark in 2013 when police officers ignored advice from the medical practitioner involved in the investigation, and contrary to statutory guidance referred her to youth services for wasting police time and again in 2014 when she was removed from the child protection plan. Child Protection Conference Chairs, social workers and police officers working within specialist child protection teams are obliged to have regard to relevant statutory guidance within their decision making. They must understand and employ key multi-agency policies to ensure information is collated and analysed appropriately. For example, a basic understanding of partner agencies' core duties and awareness of the inter-agency escalation policy and procedure will help when leading a multi-agency protection plan effectively to ensure effective professional challenge. In addition, the crucial role of record keeping and the way in which different Courts may admit and weigh up information would enable lead practitioners to provide practical guidance to other individuals or agencies involved with the child about what information should be reported in order to provide corrobative evidence for civil or criminal proceedings. Lead practitioners should know to chase missing information (e.g. updates from services supporting Kate's mother) and actively look for gaps in order to demonstrate decision making is robust.

4.13 Finally, staff undertaking specialist assessments must also be supported to give parity within strategy discussions to staff from universal services who have developed trusted relationships with the child. In Kate's case, she reported finding it difficult to open up to her social worker, but trusted the school nurse. Excluding the school nurse from the strategy meeting in March 2015 meant that an opportunity to reengage with Kate and hear her voice was lost. Those leading child protection investigations must be able to explain risk management plans so these are fully understood by the child and all those involved in the child's life. Plans should clearly set out the responsibilities of parents/ carers to engage fully

[58] Monitoring visit, published 16.05.18 [pg110]
[59] OFSTED monitoring visit, Dec. 2019

with protection plans to detect and disrupt activity. This is particularly important in circumstances such as Kate's case where her mother was sceptical of the risk. It should be made clear to parents that any failing to adhere to the protection plan will almost always require escalation into child protection proceedings.

4.14 **LADO**: The reviewer had hoped to explore some of the practical difficulties experienced by those undertaking the LADO process. Unfortunately, the relevant professional involved in this case no longer works for the Local Authority and chose not to contribute. Instead the review has considered the multi-agency procedures. This sets out roles and responsibilities for all organisations which include a requirement to have safeguarding polices and a designated senior officer to manage allegations against people that work or volunteer with children.[60] The procedure sets out timescales and provides guidance on actions required by the organisation, LADO and (if required) police. There is an expectation that most investigations will be completed within one month with 'all but the most exceptional cases completed within 12 months.' The LADO is required to track progress of all investigations and report this to the LSCP and Department for Education as required. Guidance on how information regarding the allegations should be recorded on CSC case files for children involved in the investigation are also detailed, including requiring the LADO case reference, but is explicit that information should not enable the alleged perpetrator to be identified. The investigation into CD's behaviour was not fully concluded, although in subsequent correspondence between police staff and the LADO both express concern over the nature of allegations and lack of clarity as to whether it would be lawful to disclose the allegations if future DBS or reference requests were made. The LSCP may wish to give further guidance on standards of proof required to substantiate allegations, in line with Lady Hale guidance on this issue, namely that it is only when the nature of civil proceedings are to punish or deter criminal activity they must produce evidence to meet the criminal standard of proof (beyond reasonable doubt). In all other civil proceedings, it is the civil standard of 'balance of probabilities' that applies. She advised "*neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts*."[61]

4.15 In addition, in January 2020 the Office for Civil Society published an online toolkit[62] to support organisations report safeguarding allegations against a person working within their organisation. Funding has also been made available to develop factsheets, tools and model policies and, depending on the location and nature of the organisation, provide face to face training. The LSCP may wish to consider supporting organisations in their area access this training and should ensure all are aware of the new resources. Organisations may also benefit from free practical guidance and risk assessment frameworks available online.[63]

4.16 **Input from universal services, therapeutic or specialist care providers**: Kate and her mother were involved with professionals working across education, social care, health and specialist alcohol services. Often those practitioners appeared unaware of the requirement and importance of disclosing information to CSC and/or the police or became frustrated that their concerns seemed to be dismissed. Although part of the 'Team around the Family' decisions appeared to be made by practitioners in isolation and without a shared understanding of the purpose of each intervention. For example, CAMHS a withdrawal of

[60] https://surreyscb.procedures.org.uk/qkpph/safer-workforce-and-managing-allegations-against-staff-carers-and-volunteers/managing-allegations-against-people-that-work-or-volunteer-with-children#s1087
[61] In *Re B* [2008] UKHL 35, pg.70
[62] https://safeguarding.culture.gov.uk
[63] For example, https://knowhow.ncvo.org.uk/safeguarding or https://safeguardingchildren.acu.edu.au/__data/assets/pdf_file/0004/1388443/Situational_Crime_Prevention_for_CSA.pdf

therapeutic support didn't prompt a re-evaluation by CSC as to whether Kate might need additional input to maintain wellbeing or even improve this. OFSTED's most recent appraisal confirms work remains to address this.

4.17 **Role of Parents, Carers, Family members and friends:** Kate's aunt spoke of the pride she and the family have for Kate and how well she has rebuilt her life. Whilst she understood the need to review this case and for practitioners to consider the role of the family in recognising and reporting grooming behaviours and suspected sexual abuse, she also wanted to stress how frightening the period was for her and the whole family. She explained how devious CD was and how, even when they knew he was abusing Kate, they couldn't get 'evidence' as he had coached Kate so she knew what she had to say to every question they posed. She spoke about the level of aggression the family faced from CD, how she still finds it hard to imagine how Kate coped alone with that and the pressure of making sure she maintained the deceit. Throughout the case records and from correspondence made available to the reviewer it is clear that family members persistently requested investigations into his conduct, including by approaching the youth organisation, police and CAMHS directly. She spoke of being made to feel like she was the enemy or an inconvenience for repeatedly raising her concerns with practitioners. She wished they'd been given one central point to raise concerns and report new information and was frustrated that there appeared to be little coordination between hospital discharge and the child protection processes. She admitted she was angry that Kate's cries for help were ignored. Above all she wants to ensure, going forward, that practitioners understand children abused and coerced as Kate was may well be withdrawn. She suggested practitioners should plan for resistance, whilst at the same time enabling family members to maintain a trusting relationship with the child. She wished that Kate's family had been better supported to prevent contact between Kate and her abuser. She confirmed she and others had reported when he breach the 'no-contact agreement' but were not informed what, if any action, was taken as a result.

Summary of recommendations

The purpose of any serious case review is not to replicate civil or criminal processes or to apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately to improve the safeguarding and wellbeing of children and young people in the future. Findings and recommendations from this review are not intended to dilute or deflect culpability for the harm caused to Kate from both the neglect and sexual abuse she suffered whilst a child.

Policy

1. The LSCP update their multi-agency procedures to ensure greater focus on pursuing perpetrators, explicit references to statutory thresholds for investigations and legal remedies (including all civil and criminal orders) and the burden of proof or use of collaborative third party information. The sexual exploitation risk guidance and toolkit should be amended to provide guidance for those working in universal services on what could trigger an investigation and detail pathways for preventative, early intervention work and their role in providing collaborative information to enable child protection agencies secure legal remedies. Language in all policy documents and practice tools used must avoid victim blaming, minimising risk or deflecting attention from perpetrators.

2. The LSCP may wish to include guidance to child protection practitioners on accessing advice from agencies with expertise in the management of offending behaviours on possible risk reduction measures they can lawfully employ as part of a plan and when failure to comply with any protective measures would indicate reasonable grounds to believe a child may be experiencing significant harm. This should extend to what support should be made available to victims of abuse when perpetrators are due for release from prison.

Assurance

3. LCSP conduct an audit/ review of the police decision making in respect of the out of court disposal for wasting police time should be undertaken and consideration given to expunging Kate's record. If this is not the outcome, the LSCP (with the Police and Crime Commissioner) should write to the Home Secretary to request she explore what steps can be taken, including under prerogative powers, to ensure victims of child sexual abuse who were subject to out of court disposals or convictions linked to 'survival crime' or intimidation have their police records rectified. Kate should receive written confirmation that her records has been expunged within 3 months of completion of this report.

4. The LSCP should seek assurance that the Police and Youth Offender Services have reviewed records of other known victims of grooming and sexual abuse and rectified these accordingly.

5. The LSCP should seek assurances that social workers, CP conference chairs and police officers involved in child protection duties have received training and apply relevant guidance when interviewing children and young people, potential witnesses (including family members) and alleged perpetrators where there is a risk of grooming and sexual abuse. LSCP could investigate whether police and CPS locally can report on the use of special measures/reasonable adjustments made to enable vulnerable victims and witnesses provide evidence.

6. The LSCP seek assurance that universal services and CSC practitioners are routinely utilising the Graded Care Profile2, or similar practice tools and the CE risks assessment toolkit to measure and monitor parental/ carer capacity to recognise and respond to risk of sexual abuse, neglect

and parental substance misuse. The LSCP should conduct an audit to ensure protection plans articulate the purpose and urgency of each interventions, setting out contingency or escalation if not actioned.

7. The LSCP establish mechanisms to monitor tracking of cases that are stepped down from PLO pre-proceedings work and those removed from CP and CIN processes where risks include sexual abuse, substance misuse and/or neglect.

8. LSCP monitor arrangements for cross boundary information sharing and outcomes of LADO investigations, particularly where this indicates a Barring referral should have been made to the DBS service.

9. The LSCP seek assurances from health providers and commissioners that trauma informed therapeutic support is available locally to young people (including those over 18 who experienced abuse as children) and their extended family.

10. The LSCB disseminate to relevant agencies and seek assurance staff, including designated safeguarding leads in schools, school nursing service, voluntary and charity sector organisations received a briefing on this review and have identified ways to improve practice.

Workforce development and awareness raising

11. LSCP should consider a multi-agency practitioners' workshop or skills based programme to enhance shared understanding of the legal framework available to disrupt perpetrators and protect children at risk of sexual abuse, providing clarity on:
    - the role of parents and carers in protecting children at risk of grooming and sexual abuse;
    - legal powers and expectations (as enshrined in the UNCRC) when collating and sharing information so as to assist lead agencies (local authority, the police and CPS) progress matters into Court in a timely manner. This requires treating the child, their family support network and universal services working with the child as partners in any protection plan, giving proper consideration to disclosures or indicative behaviours from the child and wider family/ support network;
    - the evidential burden required to arrest for offences, including complicity offences, so that a child is supported through specialist interview techniques and any criminal investigation can commence at the earliest opportunity;
    - legal powers that can be employed when supporting families to ensure that perpetrators find fewer opportunities to target and abuse children. The LSCP may consider devising advice for families and young people based on Finkelhor's four pre-conditions model [see pg2.11 and section 4 of the report].

12. LSCP to raise awareness of the Office for Civil Society's and NCVO's on-line resources for organisations and charities providing services to children and adults at risk to ensure safer recruitment practices and effective safeguarding investigations. Consideration may also be given to providing a skills-based course for VCFS organisations on 'conducting an investigation following an allegation against staff and volunteer' to address common evidential and HR issues.

Kate and Fiona wish to thank the NSPCC's for providing freely available on-line research and training resources (available at: https://learning.nspcc.org.uk) so that everyone involved in promoting a child's safe development can better understand how to recognise and respond effectively when a child or young person is at risk of grooming and sexual abuse.