Serious Case Review

Sarah, Emma, Sophie and Ryan

Covering Report

Stephen ASHLEY
Independent Chair
1st December 2016

Introduction

This report is accompanied by the serious case review report written by Bridgett Griffin, an accredited SCIE reviewer.

I felt, as the independent chair of the board, that it was necessary to clarify and seek to address some of the issues that are bound to be raised around this serious case review, and the process that has been followed.

The first issue that I seek to address is the time it has taken to produce this report. On my arrival in Hillingdon in August 2015 this report had been commissioned and the previous chair had laid down the process and style she wished to see adopted. The independent chair and lead reviewer for the process had been appointed. There had already been considerable delay caused by various court proceedings that were underway. Clearly, these criminal proceedings take priority and so some delay was inevitable.

The fact is this report now sits in the same category as many of those that have attracted criticism from the National Panel. Whilst there are some valid reasons for the delays, they are excessive. I can say that a huge amount of work has been undertaken in Hillingdon and, whilst this report is long overdue, the agencies involved have been quick to respond and have been working diligently to improve processes, awareness and service delivery over the last two years. I provide a summary of that work later in this report.

The second issue that I will address concerns the style and length of this serious case review report. Again, it provides an example of the type of report the National Panel has previously commented upon. It is long and complex (125 pages) and the key issues take some time to work through. There are 128 recommendations. That is why I have provided a summary of the events, the key issues and the work being undertaken in response to the incidents contained in the original report. The reviewer produced a report that was requested by the previous chair of the board who had stated, understandably, that she wanted, “no stone left unturned”. The author has followed that guidance in producing the SCR report.

This report provides:

- A summary of the case
- The rationale for requiring a serious case review
- A summary of the key incidents
- The key themes
- Recommendations
- The work conducted to address areas of poor practice and improve the level of protection of our children

Case Summary

The review examined a period between 1st January 2011 and 6th August 2014. The report concerned four children; Sarah, Emma, Sophie and Ryan.

Sarah and Emma were 'looked after' children and had made allegations of rape. These allegations were not followed up at the times they were reported, and in addition, both girls were engaged with professionals who were made aware that both children were involved in high risk and underage sexual activity. The review found that professionals did not appropriately deal with this and as a result these children were the repeated victims of child sexual exploitation (CSE).

Sophie was not 'looked after' but was known to children's social care. Sophie had regular contact with sexual health services and provided information to health professionals that suggested she was engaged in sexual activity from a young age. In this case information was not shared by agencies and her exposure to child sexual exploitation was not recognised by professionals.

All three girls exhibited risky behaviours associated with CSE but these were rarely identified, assessed or addressed by agencies and information was not shared.

Ryan was a person of concern with regard to sexual exploitation who was placed at considerable harm as a result of his engagement in criminal activity and drug use. Ryan's inclusion in this review is a matter that will cause some debate but it does highlight the need for agencies to engage and protect children to prevent CSE, whether that be as victims or potential perpetrators.

In September 2013 the London Borough of Hillingdon identified that organised child sexual exploitation was taking place in the borough linked to drug taking and criminal activity. A joint police and children's social care investigation was launched called Operation Baker. The investigation led to the arrests and successful prosecution of five individuals. Four of those individuals received custodial sentences for serious sexual offences and the fifth, a suspended sentence for drugs offences.

Criteria for a Serious Case Review

In December 2014 a review was carried out by Hillingdon Local Safeguarding Children Board that identified; *"a number of missed opportunities to protect Sarah and Emma and that both were subject to significant harm as a result of being subject to sexual exploitation. In addition some poor interagency work was identified together with a failure to follow both local and national practice and procedure."* Sophie and Ryan were to be included in the review as a result of further investigations.

The independent chair of the board concluded that the Working Together 2013 criteria had been met to instigate a serious case review.

Summary of key incidents

There were a large number of interactions between the four subjects and the safeguarding agencies. The following three incidents were highlighted in the review as being of particular significance:

- In spring 2011 Sophie attended a sexual health clinic and told a nurse that she had had sex with a casual partner over the previous two years. Sophie was only just fourteen years old at this time she made this report. The professional took no action despite knowing Sophie had been having sex since she was twelve years old.

- In the summer of 2011 Sarah alleged that an adult male had raped her. The matter was reported to the police who conducted and interview with Sarah. A suspect was interviewed but no further action took place and children's social care were not engaged; no strategy meeting took place.
- In the winter of 2012 Emma reported that whilst in a residential placement, Ryan whilst under the influence of drugs had had sex with her without consent. Emma reported this to social care and the police were informed. Emma refused to provide a statement despite the engagement of a social worker and Emma was moved to foster carers "out of borough'. There was a failure to follow the safeguarding procedures and a lack of understanding of the effects of CSE.

These incidents are just three of a number of incidents where frontline professionals did not follow statutory child protection procedures to investigate information that suggested Sarah, Emma and Sophie were at risk of significant harm.

Strategy meetings did not take place and information was not therefore shared between professionals. Professionals investigated incidents in isolation and not in a multi-agency forum, which resulted in a failure to provide a response that protected these children.

Key Themes

The lead reviewer has highlighted twenty learning points that give considerable detail in this case. The key themes that are distilled from these learning points are;

- Confusion about what normal sexual behaviour in teenagers looks like.
- Normalising of evidence of exploitative relationships.
- Behavioural indicators of sexual exploitation interpreted as 'lifestyle choices'.
- Ineffective Looked After Child (LAC) reviews and LAC processes that, assumed that looked after children were safe.
- Poor senior management oversight and lack of direction by the Safeguarding Children Board.
- Lack of challenge and escalation.
- Ill-informed placement choices.
- Health focus on providing treatment rather than considering risk of CSE.
- Lack of understanding of perpetrators.
- Guidance not being followed, known or understood by frontline staff; resulting in failures to respond to serious allegations of sexual harm.
- Failures to make use of child protection procedures, including strategy meetings.
- Confusion over how to assess power differential in teenage relationships and what variables to consider in making an assessment in this area; with particular reference to consent (learning difficulties, emotional functioning, vulnerabilities etc.).
- A lack of professional curiosity/ appreciate inquiry in relation to what the teenagers were saying about their lives and experiences.
- A clear lack of understanding between the police and sexual health professionals about working together in relation to CSE.

The full report contains considerable detail and evidence around these key themes and learning points. These themes have formed the basis of recommendations in the report and the consequent work plans to steer improvement.

Recommendations

The serious case review report has listed recommendations under each of the twenty learning points. There are 128 recommendations in all for the board to consider.

In my view it would have been more practical to have a considerably more succinct list for agencies to deal with. The recommendations take the form of questions to the board rather than specific suggestions to improve practice. As a result agencies have been tasked with producing work plans to address specifics within the report, as well as more generally to explain how in practice they deal with CSE and how it is managed in the borough.

Action Taken in response to Operation Baker SCR Report

A huge amount of work has been undertaken to deal with the issues that came to light as part of this review and other well documented CSE cases around the country. The following bullet points provide some information on the work plans and the outputs that have resulted. Work plans are monitored through both the HLSCB CSE sub-group and the HLSCB SCR sub-group.

The key points are:

- Community safeguarding lead posts were fully staffed from 2011 to the present day; there are no significant gaps in service provision. 'Supervision' guidelines for community children's teams specify that 'supervision' must be accessed every 3 months as a minimum, and will be delivered by 1:1 sessions and in groups.
- Children attending A and E and Minor Injuries Unit are assessed for safeguarding risks including a specific CSE risk assessment for children who are sexually active. These children are discussed in a weekly multi- agency meeting with a representative from the Multi-Agency Safeguarding Hub (MASH), Mental Health Services, Community Services (Children) and Drugs and Alcohol Services. This is to ensure that information is shared and appropriate referrals have been made. Pregnant children are assessed by midwives, doctors and nurses working in the Early Pregnancy Unit.
- All children attending sexual health services are discussed with Named doctors and the nurse for safeguarding children to ensure that CSE or other forms of child abuse are further assessed and appropriate action taken. This information is also shared with Community Service (Children) via the Paediatric Liaison Health Visitor who attends the meetings.
- The hospital trust has updated its Safeguarding Children Policy and a clear CSE section has been added to allow staff to know what to do if they are concerned.
- The Hillingdon CSE Strategy and action plan was launched June 2011.
- There is commitment of ownership to the CSE Prevention and Intervention Strategy from the highest level within all agencies.
- A dedicated CSE Prevention Manager post was created in the Safeguarding and Quality Assurance Service.
- A designated detective sergeant and constable are located in the MASH which has enabled a prompt response to CSE level 1 concerns.

- Operational working together between partner agencies has improved significantly and been tested through auditing processes.
- There is good level attendance at the Multi-agency Sexual Exploitation (MASE) meetings including;
    - police officers from the MASH, MISPER unit and Central CSE unit,
    - health and education professionals,
    - children's social care, Early Help and Prevention, Youth Offending Service professionals and
    - third sector providers.
- A Children/Young people's profile template supports social workers to update the MASE panel. Allocated social workers and their managers present cases to MASE.
- The CSE Prevention Manager delivers 'Introduction to CSE' training throughout the year to all agencies and attends various locations to deliver training in order to raise awareness.
- Hillingdon has created a CSE resource pack, which is sent out to professionals.
- A comprehensive Victim Support Policy, which contains pre and post-trial support for victims has been developed and implemented.
- A CSE process document has been developed and is given to all front line workers in their induction and through ongoing CSE training.
- A Hillingdon Information Sharing Protocol has been developed from Working Together and Pan London guidance.
- CSE Risk Assessment and CSE toolkit embedded in practice.
- A 'drop-down' and specific CSE risk assessments are live on LCS (local computer system) therefore data can now be retrieved.
- Reporting is addressed at the quarterly CSE sub-group of the LSCB.
- Hillingdon have undergone two CSE peer reviews. The most recent review used the Ofsted JTAI framework for CSE.
- A 'Missing Tracker' is operational with information retrieved from LCS.
- A fortnightly virtual missing panel tracks all children and young people missing from home and care. There is a weekly update on numbers missing provided to senior managers.
- Return Home Interviews are completed, as evidenced in audits (Independent Return Interviews contracted out to NYAS).

In addition, the Lead Member for children services receives a monthly briefing on specific CSE issues and the Corporate Director for Adult, Children and Young people and senior officers are required to provide assurance to the council scrutiny committees.

Conclusion

This serious case review was instigated in Hillingdon to review the cases of four children who had been let down by a number of agencies. Three girls were subjected to serious sexual exploitation and abuse and this could have been addressed at an early stage if professionals had understood the problem and followed child protection procedures. The fourth child was at high risk of causing harm to himself and others, and again professionals failed to understand and deal with this risk.

It is of no consequence that at this time professionals across the country were struggling with these issues or that similar cases have been identified in other areas.

The fact is that professionals in Hillingdon could, and should, have done more to protect these children.

Ultimately Operation Baker was a success and served to punish perpetrators and to highlight the earlier failings of the agencies, however it came too late.

Agencies have acknowledged that more could have been done and have worked hard to ensure that the risks to children of sexual abuse and exploitation are understood and dealt with. There is now clear evidence that agencies in Hillingdon work together to protect children from this type of abuse. There can be no complacency, and I as chair of Hillingdon Local Safeguarding Children Board, will ensure that child sexual exploitation remains a priority for those agencies charged with the protection of our children.

Stephen Ashley