SCIE Learning Together

social care institute for excellence

West Sussex Safeguarding Children Board

Serious Case Review

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1 EXECUTIVE SUMMARY

1.1 CONTEXT

1.1.1 The modern child protection system has developed, in part, from the learning from child abuse tragedies primarily about children that were killed by their parents / carers, most famously Maria Colwell (1973), Jasmine Beckford (1985), Victoria Climbie (2000) and Peter Connelly (2007). This abuse within families has also been the main focus of serious case reviews.

1.1.2 In more recent years we have extended the multi-agency safeguarding system to include the protection of children from harm outside their families and in the areas of public protection. The child protection procedures have widened during the last 20 years to include such wider circumstances of public protection, for example 'Sexual Exploitation' and 'Children who harm others'.

1.1.3 The vast majority of serious case reviews undertaken nationally are initiated as a result of children being harmed by their parents/carers and hence the primary learning from practice has centred on this type of abuse. This has led to a focus on the core part of child protection procedures, which is the process outlined in the government guidance Working Together to Safeguard Children (1989, 1999, 2006, 2010 and 2013).

1.1.4 In recent years this has begun to change with high profile criminal prosecutions involving Child Sexual Exploitation and subsequent serious case reviews being published. This has led to increased professional awareness of the procedures covering this crime, contained in the 'specific circumstances' section of local child protection procedures.

1.1.5 This serious case review examines the way agencies responded to allegations made by children that they had been subjected to sexual assault by another child, a few years older than the alleged victims and known to them. West Sussex Safeguarding Children Board is not aware of any previous reviews into this area of practice i.e. abuse outside the family by another child, and anticipate that this may provide a platform to raise awareness and trigger further local and national attention to the issues raised.

1.1.6 West Sussex Safeguarding Children Board (WSSCB) identified that this case held the potential to shed light on particular areas of practice including addressing the following questions:

- How can we effectively identify, understand and manage risk to and from child sexual abusers?
- How can we effectively respond to children who report sexual abuse by other children/young people?
- How can we effectively support children who pose a risk of sexual harm to other children?
- How can we effectively work with parents of children abused by other children when they are reluctant to engage?

1.1.7 This review set out to understand what happened and why. The SCIE methodology was chosen as it was believed to be most appropriate to help answer the above questions, and to provide a window on the current safeguarding system. The review has explored why things happened and provides the WSSCB with a number of findings to consider.

1.2 WHAT HAPPENED?

1.2.1 This case involves the responses of agencies between January 2011 and March 2013 to allegations of sexual abuse made by a number of young boys in the context of earlier allegations made in 2009 and 2010. All the young people were aged under 18 at the time the allegations were made and the perpetrator (to whom we have given the pseudonym John) was also aged under eighteen at the time the offences were committed.

1.2.2 Despite being investigated there was insufficient evidence collected for prosecution until late 2012 and the perpetrator maintained (and continues to maintain) his innocence throughout. He was convicted of a range of 49 offences in October 2013, including rape, and was sentenced in January 2014 to 10 years in prison, 8 years extended licence and a Sexual Offences Prevention Order.

1.2.3 Overall the review established that agencies would have benefitted from:

- Undertaking timely and adequate enquiries into allegations
- Consistently linking together the various allegations made over time, so as to obtain a comprehensive picture of the risks involved
- Adequately considering the implications for the safety of other young people who may have been at risk from John

1.2.4 Furthermore on one occasion there was the lack of recognition that the allegation being made did indeed constitute an offence, and on another occasion a new allegation about a third party was not investigated.

1.2.5 In October 2012 the Police were informed of an allegation for which substantive evidence was available. From that point the investigation proceeded appropriately, links were made with previous allegations and this resulted in John being prosecuted and convicted in 2013.

1.2.6 The detailed description of what happened and the appraisal of the practice is provided in section 3.

1.3 WHY IT HAPPENED

1.3.1 Section 4 of this report provides the factors that contributed to the decisions, actions and inactions that occurred in this case whilst section 5 provides the underlying systemic findings that give a deeper understanding of the reasons for the practice shortcomings that are described in section 4.

Background

1.3.2 In 2008 and 2010 Ofsted identified significant shortcomings in the safeguarding of children in West Sussex which led to a reconfiguration of Children's Social Care and notice to improve the services provided, including the consistency, quality and

timeliness of the response to new referrals. The 2013 Ofsted inspection recognised these improvements with Children's Safeguarding graded as 'adequate'. However, the evidence from this review is that whilst overall performance may have improved, more needs to be done to address and embed the responses in the specific circumstances of this case, namely when a child is alleged to have abused another child or other children.

Findings

1.3.3 In fact the first of the seven findings of this review (see section 5) is that practitioners involved in this case did not know of the existence of the specific procedure 'Children who harm others' and were in consequence following the basic child protection process as contained in 'Assessment & Managing Individual Cases where there are concerns about a child's safety section'. This is the child protection process as outlined in Working Together to Safeguard Children.

1.3.4 Following this basic process led to an individual response to each individual allegation and a focus on the safety of the children within their own family. Attempts to provide therapy and risk assessment via mental health services to the alleged perpetrator were unable to be progressed in the face of his denial and refusal to attend such appointments. The pertinent specific procedure, which was not followed, provides for linking all the allegations and for multi-agency processes to consider the risk to other children i.e. the public protection risks.

1.3.5 Despite 'road shows' to publicise the new integrated electronic procedures in 2011, the reasons behind these practitioners lack of knowledge of the specific circumstances procedure relates partly to:

- The history of the procedure manual being split into Parts One and Two, with all practitioners being provided with Part One in hard copy: this covered the basic child protection process, whilst the specific circumstances were in Part Two
- The continuing preference by some members of staff for using out of date paper procedures and despite instructions to destroy the previous editions, paper procedures remaining accessible in some workplaces
- The use of Management Instructions within Children's Social Care which have taken over as being the prime reference source for managers and staff in social care and are not entirely consistent with the procedure manual. The Management Instructions are explicit in stating that they do not replace Pan Sussex procedure, but it became clear that staff increasingly used them as the first source of procedural guidance.

1.3.6 Another major factor (see section 5, Finding 4) is that agencies are accustomed to dealing with abuse within the home and may struggle to tackle abuse occurring outside of this environment (**Research in Practice** *Children and young people missing from care and vulnerable to sexual exploitation 2013)*

1.3.7 This leads us to a finding of the lack of clarity in West Sussex in roles and responsibilities when the threat to a child's safety is external to the family, in particular when the alleged perpetrator is also a child. This highlights the feeling of 'helplessness' in professionals in such circumstances, compounded when the

suspected abuser is a child who denies the allegations and when there has been insufficient evidence obtained.

1.3.8 The critical public protection function was not identified by Police or social workers as their responsibility; social workers identified their role as dealing with the safety of children within their family and Police restricted their action to criminal investigation, without considering the need to progress matters on an intelligence led basis. A further complicating factor was the lack of clarity about information sharing arrangements in these circumstances and outside of the framework of a s.47 enquiry[1] (commonly known as child protection enquiry).

1.3.9 Until October 2012, there was a lack of evidence obtained for the Police to be able to progress a criminal investigation. It may be that this would never have been possible to obtain, but the chances of detecting and prosecuting John earlier would have been enhanced if all the investigations had been timely and child focused, so as to respond when the child is prepared to speak and in a sufficiently holistic supportive manner. It was concluded that this works best when the Police Child Protection Team [CPT] work jointly with Children's Social Care. When other branches of the Police take the lead investigating role, this may provide a timely response, but the lack of early social work involvement can lead to problems around the identification of abuse as well as difficulties in forming a relationship so as to be able to provide the children and families with on-going support (See section 5, Finding 2).

1.3.10 One of the features of child protection practice that limited the ability of Children's Social Care and Police to see the links and consider public protection, was the lack of involvement of other agencies as partners in enquiries and assessments. In particular the GP and the school were not included adequately in such processes. This was perceived to be a custom and practice issue and steps have already been taken to make both strategy discussions[2] and social care assessments more inclusive of other agencies. It is important that the extent to which this has changed is established (see section 5, finding 3).

1.3.11 There have been and continue to be obstacles for quick and accurate identification of history and associations in circumstances when there are a large number of victims involved due to complex database arrangements within CSC and Police and the reliance on individuals to insert and maintain linkages (See section 5, Finding 3).

1.3.12 There was a lack of effective support and intervention resources available or offered to John, because he denied the allegations and did not wish to attend the appointments offered by either the Assessment and Treatment Centre (ATS) or (after one session) by the Child & Adolescent Mental Health Service (CAMHS).

[1] s.47 enquiry refers to section 47 of the Children Act 1989 which gives local authorities the duty to 'make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare' when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm

[2] A strategy discussion or meeting is convened when there is reasonable cause to suspect a child has suffered or is at risk of suffering significant harm. The purpose if for agencies to share information and decide whether to initiate or continue enquiries under s.47 of the Children Act 1989, and to plan any such enquiries

Section 5, Finding 6 discusses the need to develop the multi-agency working with the Assessment, Intervention and Moving On (AIM) provision.

1.3.13 CAMHS worked in isolation within the multi-agency safeguarding environment. When John did not attend a second appointment, there appeared to be no reflection or review and consideration of the information obtained at the initial appointment with CAMHS, despite concerns being identified. CAMHS did not consider enquiring if John was known to Children's Social Care and/or the need for more pro-active follow up. The reasons behind this relate to a lack of systems to provide a consistent approach within CAMHS to failure to attend appointments and to multi-agency liaison, despite the existence of a policy across the Trust concerned (see Section 5 Finding 7).

1.4 COULD IT HAPPEN AGAIN?

1.4.1 The findings in section 4 explain the underlying strengths and vulnerabilities in the way agencies in West Sussex respond to allegations of a child harming other children. If these findings are not addressed the multi-agency safeguarding system will continue to have the weaknesses described and the same practice shortcomings could occur again.

1.5 WHAT WILL THE LSCB DO IN RESPONSE TO THIS?

1.5.1 At the end of each finding in section 5 considerations have been listed for the WSSCB. These are questions to assist the Board to decide on the optimum action to take. The WSSCB has prepared a separate document in response to these considerations which describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

2 INTRODUCTION

Why this case was chosen to be reviewed

2.1.1 This case involves the serious and persistent sexual abuse of a number of children over a number of years by a young person, himself a child at the time and known to all the victims. The perpetrator of the abuse is called 'John' throughout this report; this is not his real name.

2.1.2 The serious case review sub-group of the West Sussex Safeguarding Children Board recommended that a serious case review be initiated in May 2013, when following a Police investigation in 2012/ 2013 John had been charged with 55 sexual offences. Whilst some of the victims were not known to agencies in West Sussex, at the time of his arrest there was knowledge locally of allegations concerning six of the victims.

2.1.3 The WSSCB independent chair, Jimmy Doyle, decided to initiate a serious case review in July 2013, on the basis that the criteria were met i.e. that children had

been 'seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together '.[3]

2.1.4 The case was additionally perceived to provide learning opportunities more generally about the way that agencies respond to allegations of sexual abuse made by a child against another child ('child on child'); this has not been the subject locally (or as far as is known nationally) to such a learning exercise and the WSSCB wishes to improve multi-agency interventions in this field.

Succinct summary of case

2.1.5 Between May 2009 and October 2012, Children's Social Care and/or the Police received a number of allegations from children within a Sussex village of sexual abuse. All these allegations cited the same young person, who was also a child at the time, as the alleged offender. Four were first-person allegations and a further six were anonymous or about another child and/or non-specific.

2.1.6 It was not until late 2012 that the Police obtained a high standard of evidence from a young person who was willing to be interviewed, was supported by his parents, and there existed corroboration of offending via a social networking site. The Police immediately launched a criminal investigation, which led to John being prosecuted for 50 offences and convicted of 49 in October 2013.

Organisational learning and improvement

2.1.7 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. '(Working Together 2013:66)

[3] Working Together to Safeguard Children 2013

2.1.8 West Sussex Safeguarding Children Board identified that the serious case review of this case held the potential to shed light particular areas of practice including addressing the following questions:

- How can we effectively identify, understand and manage risk to and from child sexual abusers?
- How can we effectively respond to children who report sexual abuse by other children/young people?
- How can we effectively support children who pose a risk of sexual harm to other children?
- How can we effectively work with parents of children abused by other children when they are reluctant to engage?

Structure of the report

2.1.9 The report is structured as follows:

- Section 3 explains the methodology used for the serious case review
- Section 4 explains what happened, why and gives an appraisal of practice in this case
- Section 5 provides the findings about what needs to happen in the multi-agency safeguarding systems to reduce the risks of recurrence
- A glossary of terms and abbreviations used is provided at the end of the report

3 METHODOLOGY

3.1 INTRODUCTION

3.1.1 Statutory guidance[4] requires serious case reviews to be conducted in such in a way which:

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

3.1.2 In order to comply with these requirements West Sussex SCB has used the SCIE Learning Together systems model[5]. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families, and make it more or less likely that the quality of practice will be good or poor. Solutions then focus on redesigning the system to make it easier for professionals to safeguard children well and harder to safeguard children poorly.

3.2 SCOPE OF REVIEW

3.2.1 The practice being reviewed is the involvement of agencies and responses to allegations of abuse against John during the period January 2011 to January 2013, when the last known local victim contacted the Police. This time period was selected to provide the most useful learning about current safeguarding systems.

3.2.2 The first allegation made against John was in May 2009, but the decision to focus on the more recent timeframe was in recognition that:

- The earlier significant shortcomings in the safeguarding system were well known: Children's Social Care was graded inadequate in 2008 and 2010 (see 4.1.6-4.1.9) and
- Rather than learn about weaknesses to multi-agency systems that have already changed, a more recent focus will provide information on current practice
- This is consistent with SCIE's methodology to focus on recent practice where staff are available to participate and recall events

3.2.3 This report acknowledges that much of John's most recent offending was carried out via social networking and involved victims primarily outside West Sussex. The serious case review has not investigated this aspect of John's offending because it was acted on as soon as it was reported, and local agencies had no prior knowledge or involvement in this aspect of John's offending.

[4] Working Together to Safeguard Children, 2013 Chapter 4
[5] Learning Together, Fish, Munro & Bairstow SCIE 2008

3.2.4 Some of the victims did not give evidence in court. This means that there is not a complete link between John's final convictions and the allegations received during the review period.

3.3 REVIEW TEAM & INDEPENDENT ROLE

3.3.1 The process has been led by Edi Carmi, an independent reviewer, working closely with two internal lead reviewers Susan Ellery and Lorraine Smith.

3.3.2 Edi Carmi has extensive experience of writing serious case review reports both under the previous 'Chapter 8' framework and the SCIE methodology. She is accredited by SCIE to carry out Learning Together reviews and has been working with SCIE since 2009 as part of the Learning Together team on the development of the model, training lead reviewers and agreeing their accreditation.

3.3.3 Susan Ellery is the Principal Manager Children's Safeguarding at West Sussex County Council and has previous wide experience in operational management, primarily of provider services (fostering, adoption, residential, family support). She completed the SCIE Learning Together Training in 2013. She had no involvement in the case under review.

3.3.4 Lorraine Smith was Designated Nurse for West Sussex at the outset of the review process, but has since taken up post as Designated Nurse for Portsmouth & the Isle of Wight. She has been a Consultant Designated Nurse since 1995 with significant involvement in serious case reviews and as author of IMRs and Health Service Overview Reports. She completed the SCIE Learning Together Training in 2013. She had no involvement in the case under review.

3.3.5 These three reviewers worked closely with a review team consisting of a group of senior managers who work collaboratively with the lead reviewers in reading documentation, talking to staff and analysing the data. The review team are also able to provide useful evidence regarding the practice issues identified in the case. Those involved were:

- Principal Manager, Care Management WSCC
- Designated Doctor
- Service Manager, West Sussex Youth Service
- General Adviser, Compliance, WSCC Learning Service
- WSSCB Safeguarding Adviser
- Consultant Named Nurse CAMHS, Sussex Partnership NHS Trust
- Detective Inspector, Sussex Police, Protecting Vulnerable People

3.3.6 The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

3.4 DATA COLLECTION: PRACTITIONERS AND RECORDS

3.4.1 Understanding practice in context requires reviewers to engage those people who were directly involved in the case in a collaborative process of dialogue, as well as drawing on the formal documentation as a source of data.

3.4.2 Input from the key practitioners [called the 'case group'] has been gathered from them via individual conversations, supplemented by two case group meetings, when practitioners are given the opportunity to discuss, correct, amplify and challenge the factual accuracy and interpretations of the sense that the reviewers made of what happened.

3.4.3 The staff involved in these conversations and invited to case group meetings are:

- 2 Team Managers (CSC)
- 5 Social Workers (CSC)-
- 2 Designated Members of Staff and 1 Head Teacher (Education)
- 2 General Practitioners
- A Psychiatrist and a Psychologist (CAMHS)
- 3 Detective Sergeants (Police)
- 2 Detective Constables (Police)

Data collection: young people and families

3.4.4 Attempts have been made to involve the victims and their families through letters before and after the criminal trial. Only one parent and child has taken up the opportunity to participate in the review.

3.4.5 A decision was made to defer trying to talk with John or his mother until after he had been tried and sentenced. This occurred on 24.01.14. After an abortive attempt to visit him, to discover he had been moved, John was visited in prison on 14.03.14 and his mother was seen on 20.03.14**.** Their views on the services received are included in section 4 and section 5 (Finding 4).

Timescales

3.4.6 In line with Working Together 2013, the aim was to complete the review within six months. The process was delayed by the trial which took place in September / October 2013, and by sentencing which was completed in late January 2014. Consequently there were restrictions in being able to have conversations with the young people, families and some staff.

Methodological comment and limitations

3.4.7 The limited response of the young people themselves and their families is understandable as after the lengthy criminal process, it may be that they now wish to distance themselves from what has undoubtedly been a traumatic experience. However, this means that the serious case review has been limited in its ability to learn directly about their experiences of the services provided and the changes needed so as to provide a safer and more supportive experience for those in similar circumstances in the future.

3.4.8 Information from the college John attended was limited due to a key member of staff having left and efforts to locate her being unsuccessful. We did find that there was no written record of the allegation of sexual harassment said by John's mother to be a driver for his suicide attempt in early 2011 (see 4.2.12).

3.4.9 A team manager had left Children's Social Care and an officer in the Police Child Protection Team [CPT] was unavailable in the later stages of the SCR. As a result the review team could not re-interview them and get a full picture about why a new and serious allegation about Victim 8 was completely overlooked in late 2011/early 2012. However, the team manager and CPT Officer were interviewed in the early stages of the review and neither could remember why they had made the decisions they had or why they had overlooked new evidence.

4 PROFESSIONAL PRACTICE APPRAISAL

4.1 INTRODUCTION

4.1.1 This case involves the responses of agencies between January 2011 and March 2013 to allegations of sexual abuse made by a number of young boys in the context of earlier allegations made in 2009 and 2010. All the young people were aged under 18 at the time allegations were made, and the perpetrator was also aged under eighteen at the time when most of the offences were committed.

4.1.2 Despite being investigated there was insufficient evidence collected for prosecution until late 2012 and the perpetrator maintained his innocence throughout. He was convicted of a range of 49 offences in October 2013, including rape, and was sentenced on 24.01.14 to 10 years in prison, 8 years extended licence and a Sexual Offences Prevention Order.

4.1.3 This section provides an overview of 'what' happened in this case and 'why'. Sometimes the explanation for 'why' will be explained in the findings in section 5 and a cross reference will be provided in this section.

4.1.4 Along with the explanation of what happened, the following makes explicit the view of the review team about the timeliness and effectiveness of the responses provided to victims, perpetrator and families, including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time.

4.1.5 Individual children, who either made allegations or were reported by others as having been subject to abuse by John, are referred to as victim 1, victim 2 etc. The number reflects the order in which agencies became aware of their existence from 2009. The professionals involved are anonymised in the same way, e.g. social worker 1, 2 etc.

Context prior to January 2011

4.1.6 Safeguarding practice in West Sussex during 2009-2010 was acknowledged at the outset of this process to have been inadequate. This was identified by Ofsted in late 2008 when Safeguarding in Children's Social Care was graded as Inadequate. During 2009 and 2010 there were continuing deficiencies in the safeguarding systems, which were identified in the Ofsted inspection of November 2010. The Ofsted report, published in December 2010, criticised the timeliness and quality of assessments and stated, 'In too many cases seen by inspectors, there was very significant delay in identifying concerns, in visiting children and in completing assessments, including section 47 investigations… The quality of too many assessments and section 47 investigations is poor. Management oversight is inadequate in too many cases, resulting in a lack of prioritisation and drift in action to protect children. This has led to delays in protecting children and in children and families gaining access to services'. Children's Social Care was subsequently re-organised to improve the consistency, quality and timeliness of the response to new referrals.

4.1.7 The practice in this case during the earlier period was characterised by long delays in response. By the time Children's Social Care and/or the Police spoke to victims they were not prepared to provide evidence for the Police or want the support of Children's Social Care. We cannot be certain that this would have been different had the response been timelier; a young person who agreed to be interviewed explained that it was very difficult for him as a boy in early adolescence to talk about being sexually abused by another boy. But he also thought that, had he been spoken with immediately, he would have been more likely to disclose what had happened.

Current context

4.1.8 The serious case review focuses on more recent practice i.e. since January 2011, so that the findings will provide us with an understanding of the current strengths and weaknesses of the way that agencies work together to safeguard children.

4.1.9 Children's Safeguarding was graded Adequate by Ofsted in February 2013. To quote from the report, March 2013, 'Senior leaders have created an open learning culture in which staff at all levels are fully engaged. This provides a focus on raising practice standards through improved supervision arrangements, quarterly quality assurance and performance workshops and compliance to procedures and guidance by social workers. This has led to significant improvements in the understanding and application of thresholds and risk and protective factors by staff. Organisational structures and the workforce have been reconfigured effectively to reflect the findings of previous inspections as well as national and local research. Social work staffing has been increased and this, together with the presence of more experienced social workers, has resulted in manageable caseloads.'

4.1.10 The improvement in the timeliness of assessments, a particular issue in this review, is demonstrated by comparative figures as follows; in November 2010 (when Children's Social Care safeguarding was judged inadequate) 58% of initial assessments and 61% of core assessments were completed within the prescribed timescale. By February 2013 (when Children's Social Care safeguarding was judged adequate) 88% of initial assessments and 82% of core assessments were within prescribed timescales. In November 2013 when Children's Social Care implemented the single assessment process 87% of initial assessments and 83% of core assessments were on time, showing that improvement had been sustained.

4.1.11 The review team aimed to use the serious case review to look at whether such overall improvements have been reflected in practice in one area: children who harm other children.

General comments on practice

4.1.12 In reviewing the agency responses to allegations, the review team was puzzled that each allegation was considered in isolation and there was no system for joining them up. Such responses are not in line with the relevant child protection procedures regarding 'Children who Harm Other Children' (Chapter 8.7 Pan Sussex Child Protection and Safeguarding Procedures), which emphasise the need for one strategy meeting to consider the needs of the victim/s and any other children who may be at risk from the alleged perpetrator with a separate meeting for the alleged

abuser. **The question of how well agencies knew the Specific Circumstances part of the procedures, what the present situation is and what should be done to increase their use is dealt with fully in Finding 1.**

4.1.13 Without such a holistic and integrated response to the allegations, the information was not collated together and used within a multi-agency context to assess risk and plan the protection of known and potential victims. This was a feature in the earlier period but continued into the period under review, which is appraised in the rest of 4.2. As one manager said, "We didn't join up the victims and the perpetrator".

4.2 THE PERIOD UNDER REVIEW

Strategy meeting: January 2011

4.2.1 The period under review starts in January 2011 when a strategy meeting was held between Police and Children's Social Care to discuss John, the abuser. The decision to convene this meeting was commendable as the manager recognised that the focus of concern and intervention needed to be the perpetrator. Previously the meetings had focused on individual victims but without obtaining the full understanding of allegations made by others, the needs of the alleged abuser or the risks he posed to others. However, it proved to be a missed opportunity as the meeting did not succeed in obtaining (or planning to obtain) either a full understanding of the allegations or of the risks he posed to others.

4.2.2 The participants at the strategy meeting believed that John had committed the alleged offences and that he posed a risk to other young people. However, the language used in written records e.g. "sexually inappropriate behaviour", down played the seriousness of the allegations rather than providing an accurate description of the alleged predatory behaviour. This might have led to a risk that future readers of the record would not understand the gravity of the allegations and the risk posed by John to others. This could lead to a consequent lack of adequate action being taken to further allegations. **This use of professional euphemisms has been an acknowledged systemic cultural problem and is discussed in 5.2.6 and 5.2.7.**

4.2.3 Although John's current education establishment (a college) was invited, they were unable to attend so the meeting was restricted to Police and Children's Social Care. No additional information was gathered from other agencies involved, but unable to attend the meeting. Had all the information known at that time been collated, and had all the agencies with knowledge of John (and especially his old school and his GP) been involved, the direction may have been different. It is acknowledged that this lack of multi-agency involvement in strategy meetings was a problem during the period. **What lies behind this lack of multi-agency involvement is explored further in Findings 3 and 4, in section 5 of this report.**

4.2.4 The outcome of the strategy meeting was a series of actions centred around the safety of children within John's family and on the assessment of John's own needs. A written agreement was undertaken about the contact arrangements with children in the family and through the completion of the core assessment[6] (which was already in progress) he would be encouraged to talk about his abusive behaviour so that he could be given the help he needed.

4.2.5 This approach did not represent a sufficiently robust response; the aim of focusing on John should have been to understand the risk he posed to others. Instead the outcome was on protecting children within John's family, but not addressing the safety of those that had made allegations and any other potential victims. The response did not take steps to address these 'public protection' issues, i.e. the potential risks to other children outside of the family. **The reasons behind this are discussed in Finding 4 in section 5 of this report.**

4.2.6 Even the written agreement designed to protect John's nieces and nephew was unlikely to be effective given that it did not address the fact that one branch of the family lived so close that the children regularly visited the household of which John was a member. **The limited use of written agreements in such circumstances is discussed in 5.2.8.**

Core assessment: January - March 2011

4.2.7 Some positive practice was shown in the core assessment: the social worker made 5 home visits, tried very hard to get John to 'open up', and challenged him about the inconsistency in his calm attitude to the allegations from the victims, as opposed to his horror at the idea that he might be a risk to children within his own extended family. The social worker used the process to flag up to John and his family that he was seen as a risk to others. However, John did not acknowledge his offending during the assessment. The social worker mentioned to the review team about feeling constantly anxious because the Police had told her she could only refer to one of the allegations and she was worried about sharing any information that was not allowed.

4.2.8 When John was visited in prison on 14.03.14 he talked about the core assessment and feeling frustrated because the social worker did not tell him why she was undertaking the assessment, but wanted to "know everything about me". He said his response was to refuse to cooperate.

4.2.9 John's mother was critical of the very limited information that was shared at this time as it limited her potential contribution to stopping John's abusive behaviour. She was clear that she would have supported a multi-agency response to manage the risk posed by John if she had been told the information she has since discovered was known at the time. Although the social worker experienced the family as giving limited cooperation, John's mother said that after the core

[6] Core Assessment: is defined as 'an in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context'. (Framework for the Assessment of Children in Need and their Families DH 2000

assessment she did what she could to monitor his behaviour by installing parental controls on his laptop, checking his phone and forbidding sleepovers.

4.2.10 The weakness of the strategy meeting was mirrored in this assessment with a lack of multi-agency involvement, the lack of a thorough history of all the alleged offences or a wider consideration of the risks posed by John to the public. **What lay behind this is explored further in Findings 1, 3 and 4 in section 5 of this report.**

CAMHS assessment: February 2011

4.2.11 During the period of the core assessment, a GP referred John to CAMHS after he had reported feeling suicidal. John talked about an attempted suicide by hanging when he was visited in prison. John thought this suicide attempt was shortly before the CAMHS appointment but his mother recalled it earlier, at age 13.

4.2.12 The psychiatrist who saw John was unaware of the history of allegations by other children, so the context was not understood when John's mother asserted that he was the subject of a false allegation (at the college) of sexual harassment. It has not been possible to discover any more about the existence or not of this allegation as there is no record of it at the college and the key member of staff has left and could not be located for the purposes of this review.

4.2.13 John told the psychiatrist that he was subject to bouts of aggression (that he had "blackouts" and punched people in the face) and that he was misusing a range of substances: drugs and alcohol. John's admission of substance misuse was recorded but he was not referred to support services, even when he failed to attend his follow up appointment. **This is further discussed in finding 7.**

4.2.14 The opportunity for joint working was missed due to the repeated failure by successive social workers to undertake checks with John's GP [as opposed to the victim's GPs], which was then further compounded by a lack of GP liaison as part of the core assessment. Consequently John's GP was unaware of the concerns about John, so was unable to tell CAMHS. **The reason behind this relates to the lack of Children's Social Care staff following the specific procedure (see finding 1) as well as a custom and practice issue of not involving all agencies in investigation and assessment (see 4.2.8 above and Finding 3 in section 5).**

4.2.15 Positive practice was seen in the fact that it took less than 2 weeks to get a "Choice and Partnership Approach" appointment[7] and that John was seen as needing further help. However, John's non-attendance at further appointments was not followed up with him by CAMHS, although his GP wrote to John 3 times. CAMHS also did not check whether John was known to other agencies before or after his appointment, or before deciding to close his case. There was no consideration given to potential safeguarding concerns around a young person who had reported a suicide attempt and considerable substance misuse, but had then not attended a

[7] The choice and partnership approach (CAPA) that is adopted in CAMHS means that the young person has an initial Choice appointment in order for the clinician to undertake a brief assessment of the presenting difficulties and assess the suitability of the young person and their family for CAMHS services. At the assessment, a decision is made as to whether the young person requires CAMHS or another service.

follow up appointment. **What lay behind this is explored further in Finding 7 in section 5 of this report.**

4.2.16 There is a theme in this review of the difference in perceptions of John as a young person, and this includes the different personae he presented to teachers and students at school, to teachers at college, to social worker 1 and to the psychiatrist at CAMHS. For example his self-reporting about aggression was substantiated during the review by one of his victims, but came as a surprise to his former school because he had never displayed behaviour difficult to manage. John's mother commented that the school always told her he was respectful and no trouble. It is not known whether this ability to adapt his presentation to circumstances is an underlying factor in his offending behaviour. Although it was a long shot, an opportunity for an insight into John's behaviour and to help John may have been lost through the lack of being able to engage John at this point. **This is discussed further in finding 7 in section 4 of this report.**

New allegations: September 2011- January 2012

4.2.17 Two new sets of allegations were received in September and October 2011 which provided potential points to undertake new investigations and obtain evidence to progress. Both opportunities were missed as described below.

1st allegations: September 2011

4.2.18 In September 2011 John's old school (by this point he had started college) contacted the Police having been made aware of allegations about John's sexual behaviour. These came to light at a summer camp but the incidents allegedly took place prior to the camp. The school referred appropriately and made the Police aware of earlier concerns.

4.2.19 Attendance by the Police was prompt as the allegation was of rape, and a sexual offences liaison officer [SOLO], rather than a Child Protection Team officer attended. A prompt response is necessary in such cases, when there is the possibility of forensic evidence being lost and it is not always possible for the Child Protection Team to provide this. Unfortunately this response was undertaken in isolation of consultation with Children's Social Care. This is not uncommon in such circumstances and can be a major weakness in joint working. **The reasons for this are discussed further in finding 2.**

4.2.20 The allegation had been initially described as 'rape' by the child concerned [victim 7], but subsequently the details were explained by the alleged victim to the Police officer. Victim 7 described John as having sometime in the past forcibly tried to kiss him and, on a different occasion (again in the past), texted him and offered him £350 for sex. Victim 7 was more than 3 years younger than John. The Police officer concluded that there had been no sexual assault and no rape and although the designated member of staff[8] did question this view initially, he accepted that the officer had heard the details from the alleged victim and it was a Police professional decision. **The issue of professional challenge in West Sussex is discussed in Finding 4.**

[8] The designated member of staff within a school is the identified lead for safeguarding

4.2.21 The subsequent written report stated that, 'There has been NO sexual assault and NO rape' and this statement was accepted by subsequent officers in the Police CID and Child Protection Team as well as by Children's Social Care.

4.2.22 The Detective Sergeant in CID, who reviewed and accepted the officer's conclusion that there was no offence, cannot recall the circumstances, given the volume of such reports received. However, she is aware that 'we are told to try not to criminalise young people' and this was abuse 'within a peer group'. This perception was however flawed as it did not take into account the 3.5 year age difference and power imbalance between John and his alleged victim.

4.2.23 A telephone strategy discussion between Children's Social Care and the Police Child Protection Team confirmed no further action by the Police on the basis of no sexual assault, but that a social worker would visit the child and his parents.

4.2.24 No one in the chain of professionals involved questioned sufficiently the judgment of the SOLO of there being no sexual assault. Moreover, despite the school and Children's Social Care putting the allegation within the historical context of previous allegations, it was not identified as being a further opportunity to try to obtain evidence against someone suspected of harming children. The decision making at this point was diverted into getting the victim to agree that his allegation could be used to re-interview John. This was accepted as a social work task by the Children's Social Care team manager1, rather than more appropriately one for Police or a joint approach. This was due to the Police's view that there was no further action required in terms of criminal investigation. **The issue of professional challenge in West Sussex is discussed in Finding 4 in section 5.**

4.2.25 The review team judged that this was indeed an allegation of an offence, and provided a missed opportunity for a joint approach by a Child Protection Team Officer and a social worker. **What lay behind this is explored further in Findings 2 and 4 in section 5.**

2nd allegation: October 2011

4.2.26 A social worker (SW2) did visit the child (victim 7) and his parents in October 2011 and was assured that he was no longer 'hanging out' with John. The child told SW2 of a serious sexual assault by John on another child (victim 8), which involved the use of a weapon. Although written on victim 7's record, victim 8 was not treated as a new referral, as should have occurred, with immediate contact made to Police for a strategy discussion. This was a significant oversight and meant the loss of another opportunity to investigate a serious allegation.

4.2.27 The reasons behind this oversight are not totally clear. The social worker's understanding was that this Police liaison was (and is) a management role in general and the manager recalled the impact the allocated worker's ill health had on the work of a small team.

4.2.28 Some 3 months later, a third social worker was tasked by team manager 1 to email the Detective Sergeant at the Police Child Protection Team to ask if there should be a strategy meeting in relation to John. The email provided some history of concerns and the details of the new allegation, but did not specifically point out this was a new referral. The allocated social worker was off sick and social worker 3 sent the

email as one of a number of tasks while acting as 'duty backup'. In effect it became an administrative task.

4.2.29 The Detective Sergeant who received the email did not identify the new referral within the narrative of several victims and responded that she saw no value in a further strategy meeting. She has no memory of making this decision but does not recall noting a new referral within the text, and believes she thought the email was about previously investigated concerns. She said she would have expected any new referral to be telephoned into the Child Protection Team immediately.

Why were these 2 critical opportunities missed?

4.2.30 Despite the consensus between Child Protection Team and Children's Social Care that John was dangerous, there was insufficient evidence to take action and these two opportunities to further investigate the allegations of abuse relating to V7 and V8 were missed by officers in both services.

4.2.31 The reasons for this stemmed from a feeling of helplessness between the Child Protection Team and Children's Social Care that saw allegations against John as inevitably going nowhere due to his being a child himself and being unable to obtain 'good enough' evidence. Within this mind-set, not sufficient attention was paid to the detail of the allegations. **The reason behind this shortcoming in the agency responses is explained in finding 4.**

4.2.32 This mind-set may also have contributed to the lack of urgency which characterises this case through much of the history both prior to the review period, and as demonstrated in response to the September and October 2011 allegations. This lack of urgency contributed to the difficulties in obtaining good evidence. It is noted, however, that a change in the team manager supervising the case led to an improvement in pace. **What lay behind this lack of urgency is explored further in Finding 4.**

May 2012

4.2.33 In May 2012 a previous victim's mother emailed the Police asking for advice because John had knocked at the door asking her son to go out. Her concerns were taken seriously and referred to the Police Child Protection Team and then on to Children's Social Care; the Child Protection Team response was thorough given that no crime had occurred and a sensitive and helpful email response was sent after an attempted phone contact.

Criminal investigation leads to prosecution: October 2012

4.2.34 In October 2012 victim 4's mother found via his social network account that John had been grooming him for sex. The Police and Children's Social Care responded promptly and victim 4 provided an Achieving Best Evidence (ABE) [9] interview. The fast response in October 2012 was in contrast with earlier responses and indicative of the Police finally having firm evidence with which to pursue investigations.

[9] ABE interviews are those that follow the guidance provided for interviewing children and other vulnerable people in 'Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses' (Ministry of Justice 2011)

4.2.35 This fast response did not involve CSC or the Police CPT; instead the ABE interview was undertaken solely by the Police CID. The driver at this point was to secure the evidence necessary to arrest John without delay as it had become clear that victim 4 had been abused by John over a period of four or more years.

4.2.36 On seeing a Press report about John in January 2013, victim 8 came forward and gave an ABE interview about the episode first known about in October 2011. The social worker allocated to undertake a core assessment to assess victim 8's needs planned to meet him at the ABE interview. However, he was interviewed by CID on a Sunday when the social worker was not able to be present. The lack of involvement of a social worker in the ABE interview is not consistent with good joint working practices and with child protection procedures. **This is further discussed in finding 2.**

4.2.37 Having missed the opportune time to meet Victim 8, the social worker subsequently tried to make contact leaving a message on the young man's mobile. When it was not responded to, the assessment was closed down as the view was that this was historic abuse, the Police were prosecuting and there was no risk of further abuse of victim 8, who was by this stage 17 years old. There was considerable delay over this latter process, reflecting the social worker's own hesitancy over his role having been effectively excluded from the ABE interview. It was disappointing to see further delay even though it did not impede the Police investigation or deprive victim 8 of support: unknown to the social worker, victim 8 and all the West Sussex victims were receiving support from an Independent Sexual and Domestic Violence Adviser (ISDVA), after referral by the Police. **What lay behind this delay and hesitancy is explored further in Finding 4.**

5 THE FINDINGS

5.1 INTRODUCTION

5.1.1 Statutory guidance requires that serious case review reports provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence[10]. Section 4 provides the analysis of what happened and why, whilst section 5 provides the findings about what needs to happen in the multi-agency safeguarding systems to reduce the risks of recurrence.

5.1.2 The SCIE Learning Together systems approach uses what has been learnt about an individual case to provide a 'window on the system' into how well the local multi-agency safeguarding systems are operating.

IN WHAT WAYS DOES THIS CASE PROVIDE A USEFUL WINDOW ON OUR SYSTEMS?

5.1.3 WSSCB was concerned that various victims had made efforts, over some years, to report the abuse they suffered and the crimes committed by John, but that it took some considerable time for John's offences to be investigated and for him to be prosecuted, during which time he continued to abuse other children.

5.1.4 It was important to not only learn what had happened in relation to this case as described in section 4, but also to consider what this tells us more generally about the way agencies in West Sussex respond to child on child abuse when it is not intra-familial.

5.1.5 4.1.6 – 4.1.9 provides the context within West Sussex of inadequate safeguarding practice in 2009-2010 and the subsequent improvements and re-organisations made in recent years leading to an adequate judgment by Ofsted in 2013. In particular, the quality assurance material demonstrates the improvements in the understanding and application of thresholds, of risk and protective factors and compliance to procedures and guidance by social workers in Children's Social Care. This information provides a general picture of improvement, but does not address practice in relation to any specific circumstances and in particular to abuse outside of the family and/or abuse by a child of other children. This case provides evidence of the extent of the progress in the multi-agency system in relation to such particular circumstances when the focus for intervention is not the individual family, but the protection of the wider public.

5.1.6 This case provides the opportunity to consider how we are best able to respond to the child victims and their parents, so as to provide effective support whilst also enabling evidence to be collected as part of the criminal investigation. Prior to the period under review it was likely that delays in following up the victims' allegations would have been an obstacle to effective support; it was important to discover if subsequent changes to safeguarding had significantly improved the service provided to children who are abused by other children.

[10] Working Together to Safeguard Children, DfE 2013 Chapter 4

5.1.7 This case also posed the question of how to respond to alleged child perpetrators of sexual offences when the evidence is not obtained for prosecution, when s/he denies allegations, and declines the available services of assessment and treatment.

5.2 SUMMARY OF FINDINGS

5.2.1 This section contains 7 *priority* findings that have emerged from the serious case review. The findings explain why professional practice was not more effective in protecting all the children in this case and in identifying John's crimes and prosecuting him at an earlier date.

5.2.2 Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding is indicative of potential risks to other children and families in the future cases, because they undermine the reliability with which professionals can do their jobs.

5.2.3 It does this by considering patterns that are supportive of good quality work and patterns that introduce or increase risk to the reliability with which we can expect professionals to achieve good quality work.

5.2.4 The review team have prioritised 7 findings for the WSSCB to consider. This serious case review involves analysis of responses by practitioners and agencies to allegations of sexual offences being made by children against another child. The nature of this work means that the majority of the findings relate to the ways professionals respond to incidents and crisis. Additionally, two findings relate to the tools available for practitioners working in this field and one to the way we communicate and collaborate in longer term work.

RESPONSES TO INCIDENTS AND CRISES

- **Finding 1:** Practitioners and managers involved in this case did not have knowledge and understanding of the particular procedure relating to children who abuse other children: if this is reflected in current practice within the wider workforce, it risks a "one size fits all" response to allegations and concerns which reduces the chances of an effective response.
- **Finding 2**: Joint working between Police and Children's Social Care in West Sussex is less child focused and less effective when CID or uniform respond in place of the Police child protection team.
- **Finding 3:** Investigation and assessment in West Sussex often involves Children's Social Care and Police without the sufficient involvement of other agencies, leading to a lack of full information to assist the process
- **Finding 4:** There is less clarity in West Sussex about professional child protection roles and responsibilities when the threat to children's safety is external to the family and from an alleged child perpetrator. This can impact on the quality of support offered to victims and their families and on a lack of strategy to address wider issues of public protection.

TOOLS

- **Finding 5:** Complex database arrangements within Children's Social Care and Police, and the reliance on individuals to insert and maintain linkages, prevents quick and accurate identification of all relevant history in circumstances when there are a large number of victims involved
- **Finding 6**: There was and is a lack of effective assessment and intervention tools in West Sussex for children who are abusers, but deny allegations and are not able to be prosecuted.

COMMUNICATION AND COLLABORATION IN LONGER TERM WORK:

- **FINDING 7**: The current Child & Adolescent Mental Health Service (CAMHS) needs a reliable system to evaluate the need for liaison with children's social care and /or pro-active follow-up of non-engagers.

Additional Learning

5.2.5 5.3 provides the detailed findings of the headlines listed above. There was, however, additional learning not represented in the following priority findings, which was already acknowledged in West Sussex, are considered to be met via the current introduction of the Signs of Safety[11] model of practice. Signs of Safety has evolved as a model of child protection practice over 25 or more years, initially in Australia and now globally.

5.2.6 The review team noted that the written records of the strategy meeting, in this case avoided the use of precise details in the description of allegations, using the term of 'inappropriate sexual behaviour' instead. It was identified that this is a risk as this euphemism covers a wide range of behaviour, including some sexual experimentation as well as sexual abuse. No finding has been made of this, as the lack of specificity in recording is being addressed via the introduction of the Signs of Safety model**.** Signs of Safety uses the voice of the child to inform the exploration of presenting problems with the parents, and results in explanations in language which parents and children understand because it reflects back to them the words they use daily and not a professional language understandable only to professionals. Signs of Safety expects professionals to model behaviour and language at all times so the use of a term as indistinct as "sexually inappropriate behaviour" should fade out.

5.2.7 This model also addresses the use of routine written agreements, regardless of whether they are able to be effective. Signs of Safety introduces a Danger Statement which sets out exactly why services are worried about the safety of a child and which informs detailed safety planning which is realistic about what a family can and will do and expects their active participation. A written agreement, by contrast, has come to be a means by which Children's Social Care tell a family what to do without taking on board whether or not the family can or will comply. In this case (see 4.2.6) a written agreement was used in relation to John's family, despite the knowledge that this would be impossible to 'Police'. Again no

[11] The Signs of Safety model is a tool intended to help practitioners with risk assessment and safety planning in child protection cases. See *Bunn, A. (2013) Signs of Safety® in England: an NSPCC commissioned report on the Signs of Safety model in child protection. London: NSPCC.*

finding has been made of this as the new model will in time address this by either replacing written agreements with safety plans, or ensuring they are developed with the recipients and take account of actual daily life.

5.2.8 WSSCB should, through the routine quality assurance processes, check the effectiveness of the changes that have been made via the introduction of the Signs of Safety model, with regard to use of specific language and avoidance of ineffective written agreements.

5.3 FINDINGS IN DETAIL

Finding 1: Practitioners and managers involved in this case did not have knowledge and understanding of the particular procedure relating to children who abuse other children. If this is reflected within the wider workforce, it risks a "one size fits all" response to allegations and concerns which reduces the chances of an effective response.

5.3.1 Written procedures provide a clear foundation to guide actions across a range of safeguarding activities. However, their usefulness depends on practitioners' familiarity with the procedures, readiness to consult them and accessibility of use. This case has suggested a pattern whereby the practitioners were familiar with routine aspects of the procedures, but not so with the specific procedure relating to children who harm other children. This meant that the response was erroneously based on the basic child protection process.

5.3.2 The Pan Sussex Child Protection procedures have covered 'Children who harm other children' since the first edition was published in 2006'. This covered the need for strategy meetings on the victims and on the alleged abuser as well as the need to consider 'Arrangements to protect the victim and other children...'.

5.3.3 From 2006 a multi-agency meeting was to be held when the threshold for an initial conference was not met. Such meetings would provide a multi-agency arena to assess 'needs of the child and the risk posed by them, as well as co-ordinate any other interim intervention'. 'Those invited should include participants of the strategy meeting and representatives from health (including child and adolescent mental health services), school and any other appropriate service provider, the child and her/his parents / carers'.

5.3.4 The content of this procedure has not changed significantly since the 2006 edition and still covers all these points.

How did the issue manifest in this case?

5.3.5 When discussing the response with practitioners and their managers it became apparent that whilst all believed they were acting consistently with procedures, none had knowledge of the specific requirements in these circumstances as detailed in the Sussex child protection procedure for 'Children who harm other children'.

5.3.6 Strategy discussions or meetings were not multi-agency, did not consider the needs of the victim and the alleged perpetrator and other potential victims. Instead each child victim's allegation was responded to separately, even if made at the same

time as another; strategy meetings or discussions were entirely separate and failed to bring together all allegations.

5.3.7 The procedures assume that a s.47 enquiry will be undertaken unless the 'behaviour does not constitute abuse or the child is under the age of criminal responsibility, and there is no need for further enquiry or criminal investigation'. However, in this case s.47 enquiries were not held following the strategy meeting in January 2011 and the discussion in September 2011, despite a belief at least in January 2011 that the behaviour did constitute abuse.

5.3.8 The procedure provides two options as a result of the s.47 enquiry: an initial child protection conference or a multi-agency meeting. But no initial conference or in its absence multi-agency meeting was ever held, so there was no consideration of the needs of other children (besides the victims and abuser) or of the involvement of other agencies, including CAMHS.

5.3.9 Whilst it would have been the responsibility of Children's Social Care to convene the relevant meetings, the lack of challenge from any other agency suggests that there may be a wider lack of knowledge or comprehension of the procedural requirements in such circumstances.

5.3.10 Had the procedure been followed it is likely that the allegations would have all been considered as a whole, with multi-agency meetings to consider public protection considerations. It is not possible to say if this would have resulted in an earlier prosecution.

How do we know it is an underlying issue and not something unique to this case?

5.3.11 Staff participating in this serious case review were aware of the general child protection process as applied to *all* cases, but did not know of this procedure. The reason for this is the way that procedures were made available to staff until May 2011. The basic child protection process was provided to staff individually in a little 'red book' in 2006, with the identical Part 1 of the procedures available in hard copy within offices. Part 2 covered the specific circumstances (including the one on 'Children who significantly harm other children') and this was available within offices originally, albeit over time it appears that these disappeared. Staff told us that they never saw Part 2 of the procedures and were unaware of its existence. One recalled that in her induction as a new manager in 2009, part 2 was not provided or pointed out to her. This raises the possibility that staff may not have been aware of other procedures within Part 2 of the procedures.

5.3.12 In May 2011 the Sussex procedures were updated and the new procedures were only available on-line, although within Children's Social Care staff report that hard copy versions of the original Part 1 (but not Part 2) remained available despite instructions to destroy them. The online procedures are not divided into part 1 and part 2.

5.3.13 This does though remain an underlying issue, as it was reported that hard copies of part 1 remain in offices, and are still used, despite being out of date due to some people's preference for paper guidance.

5.3.14 A further potential risk, highlighted by practitioners, arises from the use of internal instructions which guide the actions of their staff. This was *not* an issue in the practice in this case, but it was suggested it may be in the future if the internal procedures are not entirely consistent with the Pan Sussex Safeguarding and Child Protection procedures.

5.3.15 In the case of Children's Social Care their internal procedures are known as Management Instructions . These have been promoted heavily and alongside Practice Standards were introduced in 2011 in response to the Ofsted judgement of Inadequate and have been the bedrock of the improvement journey. Most of these provide internal guidance on wider issues of safeguarding not covered in the Pan Sussex Safeguarding and Child Protection procedures and the focus is on internal Children's Social Care responsibilities and processes.

5.3.16 Children's Social Care practitioners raised the potential for confusion relating to Management Instruction 20 'Responding to reports of underage or coercive sexual activity' introduced in 2012. This instruction, although providing a general cross reference to 28 different sections in the Pan Sussex procedures and making it explicit that practitioners must also use the Pan Sussex procedures, does not specify either the specific relevant procedures or the additional requirements when the alleged abuser is a child. This is of concern as staff reported in this review that these instructions have become the first, and often the only, source of guidance used. As one manager explained, given the bombardment of work, human nature leads you to rely on one source of written instructions, and the Management Instructions have become the first point of reference. Therefore whilst this didn't have an impact in this case it is important that staff and managers in all agencies are aware of their responsibility to use both internal procedures and Pan Sussex procedures.

How common and widespread is the pattern?

5.3.17 The failure to use the specific procedure was a repeated problem over several years, with different social workers, managers and Police officers. This suggests that the problem is not related to a specific worker, manager or team, but a lack of sufficient familiarity within Police and CSC with this particular specific circumstance procedure.

5.3.18 One of the review team further explored awareness of this procedure (children who harm other children) with some front line staff who had not been involved in this case. Nearly all of those who replied had not heard of the procedure and consequently would not routinely look for the procedure to use for guidance in this specific situation.

5.3.19 It is not clear from this one case review to what extent this lack of knowledge would apply to the many other 'specific circumstances' that used to be in Part 2 of the procedures, which are now in chapter 8 of the online procedures. Similarly it is not known if there are internal instructions other than Children's Social Care Management Instruction20 'Responding to reports of underage or coercive sexual activity', which are potentially confusing for practitioners.

5.3.20 There is no knowledge from this review whether this is an issue in other LSCB areas.

What are the implications for the reliability of the multi-agency child protection system?

5.3.21 One of the major tools within the multi-agency safeguarding system is the provision of commonly agreed procedures which reflect up-to-date best practice in the field. This provides practitioners with a handy and accessible source of instructions and references to guidance material.

5.3.22 To be effective such resources need to be easily accessible and comprehensive. Laming in The Victoria Climbie Enquiry[12] additionally recommended this be in a single source document (recommendation 59) because once personnel are expected to refer to more than one source of such basic instructions, it is likely that they will choose the most accessible and widely promoted. This is possibly what happened when the procedures were split in two parts prior to September 2011.

5.3.23 The introduction of internal instructions is helpful when it provides internal and additional instructions, which are clearly cross referenced to any other relevant procedures. Electronic links within the instructions and Pan Sussex procedures would enable ease of access and effectively provide the one source document as recommended by Laming.

Finding 1: Practitioners and managers involved in this case did not have knowledge and understanding of the particular procedure relating to children who abuse other children. If this is reflected within the wider workforce, it risks a "one size fits all" response to allegations and concerns which reduces the chances of an effective response.

Local child protection procedures provide practitioners and managers in all agencies with agreed instructions on how to respond to safeguarding concerns generally and in specific circumstances which warrant variations and additions to the basic process. When these specific circumstances procedures are not followed the likelihood of an effective and safe response is reduced.

The use of procedure 8.7 (Children who harm other children), if known about, would have considerably strengthened the multi-agency investigative response by practitioners at the time, as well as the pro-active public protection response (see finding 4), through making clear the need for multi-agency strategy discussions, s.47 enquiries and then multi-agency meetings. This would have been more likely to have identified and linked all allegations and considered the public protection risks with regard to John. It may not though have led to an earlier prosecution.

The sheer volume and range of the procedures has led to these additional specific circumstance instructions being less known and used by practitioners or managers across the multi-agency safeguarding system. Additionally, the use of separate Management Instructions whilst generally helpful in the circumstances of this case, potentially risks

[12] The Victoria Climbie Inquiry Report, January 2013

leading staff into the wrong process via Management Instruction 20 'Responding to reports of underage or coercive sexual activity'.

QUESTIONS FOR THE BOARD TO CONSIDER

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- How will the WSSCB urgently establish the extent to which practitioners and managers in all agencies are aware of the procedural specific circumstances relating to the 'Children who significantly harm other children'?
- How will the WSSCB establish the extent to which practitioners and managers in all agencies are aware of the other procedural specific circumstances?
- How will the WSSCB facilitate an understanding for practitioners in all agencies in the appropriate use of the entire range of procedures and the need to challenge others when this is not happening?
- Can practitioners and managers be facilitated to have access to all the instructions required for their work in an accessible document as recommended by Laming? If this is not possible, can internal additional instructions be accessible and consistent with the Pan Sussex procedures, providing *additional* but not different instructions, following the same format as the procedures and linked electronically to the correct sections.
- Given the remaining findings arising from this serious case review, the specific procedure relating to 'children who harm other children' needs to be revised so as to include:
  - References to roles and responsibility with regard to public protection (see finding 4)
  - The need for clarification of the legal framework regarding sharing of information on allegations (see finding 4)
  - The procedural response required when the threshold for a s.47 enquiry and criminal investigation is perceived not to have been met: does a multi-agency meeting still apply?
  - The need to make explicit in procedures the need to minimise delay even when no immediate risk to victims; this is to maximise the opportunity to obtain evidence and provide support, before the victim and their family find the natural desire to move on and leave a distressing event behind is greater than the urge to cooperate with a crime investigation (see finding 4)
  - Multi-agency working with ATS, to include assessment tools (see finding 5)
  - Include the provision for investigation of 'complicated abuse' as applies to alleged adult perpetrators since 2013 in procedure 8.8 Complex Abuse

Finding 2: Joint working between Police and Children's Social Care in West Sussex is less child focused and less effective when CID or uniformed officers respond in place of the Police child protection team.

5.3.24 It is widely recognised that interviewing and working with children in cases of suspected abuse requires specialist skills, in order to achieve best evidence and ensure the welfare of children. The response to disclosures of abuse should also not just be focused on investigating allegations, but should trigger a more holistic assessment of young people's needs and vulnerabilities.

5.3.25 The specialist skills and holistic focus required should be provided by joint working between specially trained Police officers and child protection social workers. This case review suggested that this specialist skill mix is not always being brought to bear on all types of investigations of child abuse. There appears to be a particular gap for cases other than familial abuse, which fall outside the remit of the specialist Child Protection Team.

How did the issue manifest in this case?

5.3.26 In this case, there were a number of occasions in which young people who had made allegations of abuse were interviewed by Police, without the involvement of Children's Social Care. The Police involved on these occasions (CID and uniformed officers) do not specialise in interviewing children but are likely to have undertaken training in ABE[13] (Achieving Best Evidence) interviews.

5.3.27 Uniform Police responded to a referral made by the school to an allegation of possible rape of a child. The initial response to the referral was made by a Police Sexual Offence Liaison Officer (SOLO) who kept CID informed that there was no sexual assault or rape. A uniformed officer made an appropriate emergency response to an alleged crime where there may be forensic evidence. They were not immediately aware of the historic nature of the allegation. The uniformed Police spoke to the young people making the allegations but failed to gather and pass on information other than whether a crime had been committed.

5.3.28 In discussion with the Review Team, it was noted that the Police control room should have contacted the Police Child Protection Team who should have contacted Children's Social Care at the time. Children's Social Care not being involved at the earliest opportunity has a knock on effect of Children's Social Care experiencing difficulty in engaging with the young people and undertaking further assessments.

5.3.29 Children's Social Care was not contacted at any stage until CID subsequently reviewed the written notification (MOGP1) prior to sending it to Children's Social Care.

5.3.30 At two other points in the review period, when victims came forward and required an ABE interview, interviews were undertaken by Police CID without a social worker. One was held on a Sunday when there is no social work service, except for the Out of Hours service which covers new emergencies, and the other was undertaken without the involvement of Children's Social Care.

[13] ABE interviews are those that conform to Achieving Best Evidence (see glossary)

5.3.31 Such Police single agency responses meant that there was no social worker involvement at the early stage of investigation. This had several consequences:

- Interviews were undertaken by officers who were not necessarily experienced in speaking with children: this is likely to have affected the quality of evidence gained at that stage as well as the decisions about whether or not a crime was committed
- The absence of social workers at this early stage made it difficult for Children's Social Care to be able to make a relationship and provide meaningful assessment and support to the victim and families: it is noteworthy that this was never achieved for any of the young people
- The lack of such support makes it less likely that a victim will proceed to giving evidence against someone that is feared
- CID focus is on whether a crime has taken place: in these circumstances without a more holistic assessment, the voice of the victim may get lost.

How do we know it is an underlying issue and not something unique to this case?

5.3.32 Police responses are organised around the types of crime and the level of urgency required as a response. Generally the Child Protection Team are the prime investigators for familial abuse, and the review and case team gave many numerous examples of positive and effective joint working in such circumstances.

5.3.33 For other offences (or in 'out of hours' or urgent circumstances) the investigation will be the responsibility of other Police services e.g. CID or SOLO. The officers who then respond to a child victim or alleged perpetrator may not have the experience, skills and training to work with children or to have an understanding of the need for joint investigations with social workers from the outset.

5.3.34 The priority for Police is whether a crime had been committed but there were concerns identified that the response was not always child focused, and did not lead to a wider assessment of needs and vulnerabilities of the child, particularly when Police concluded that a crime had not have been committed.

5.3.35 The review and case team illustrated other examples (outside of this case) when difficulties had been experienced working with CID or uniformed Police in response to a child protection referral. This was particularly in relation to proceeding without involving social workers and the investigation not always being child focused.

5.3.36 During office hours, and in accordance with ABE guidelines, a planning discussion should take place between Police and Children's Social Care prior to any ABE interview of a child victim of a sexual crime. This is less likely to occur when the CPT are not involved. It is acknowledged that on occasion there is a need to conduct ABE interviews out of hours, but when that situation arises, the Police should still seek to discuss the case with the out of hours social worker.

5.3.37 It is acknowledged that the primary focus of the majority of Police units is to conduct an expedient and effective investigation of criminal offences. There are often clear operational imperatives to secure evidence from both victims and suspects. As such, even when there is an awareness of the role of Children's Social Care, and the need for referral, this is not always initiated or is initiated subsequent

to any dealings with a child. As noted above, for the majority of Police staff this activity is conducted without the benefit of any specialist training in the joint agency procedures which are familiar to their child protection colleagues. The consequence may be that investigations are not always sufficiently child-focused, and do not include a wider assessment of the needs and vulnerabilities of the child, particularly when Police conclude that a crime has not been committed.

How common and widespread is the pattern?

5.3.38 This review involved a number of young people and a number of responses to referrals, with the same pattern of response throughout.

5.3.39 Many of the review and case team work across the county and considered this issue could apply across the county, given that the Children's Social Care referral process, and Police force, are consistent across the county.

5.3.40 It is not known if this is a national issue, or the extent to which different Police forces limit the role of the Child Protection Team to familial abuse.

What are the implications for the reliability of the multi-agency child protection system?

5.3.41 An investigation that involves children needs to be able to both:

- Obtain the best evidence and
- Provide a holistic response to the victims which offers support from the outset to the victim and her or his family

5.3.42 Disclosure is difficult for children in child on child abuse, but the chances that the victim will be able to speak openly and provide the evidence is maximised if the interviewers are trained and experienced in working in this field with young people.

5.3.43 If Children's Social Care is to be part of an on-going assessment and supportive plan for a child or young person, involvement at the earliest opportunity is critical. In this case, when Children's Social Care were not involved at the outset, they were unable to subsequently engage with the young person.

5.3.44 The lack of involvement of social workers in ABE interviews does fly in the face of the intentions of the ABE framework as set out in Achieving Best Evidence in Criminal Proceedings, Guidance on interviewing victims and witnesses, and guidance on using special measures [MoJ March 2011[14]].

5.3.45 Paragraph 2.20 states; "At a minimum, such as instances in which the child has experienced no previous contact with the public services, the investigating team in child protection cases should include representatives from both the Police and the local children's services authority. It may also be important to involve primary health care or educational professionals who know the child".

5.3.46 Subsequent paragraphs refer to the strategy meeting including at a minimum Children's Social Care and the Police, and to the Police being responsible for the criminal investigation but decision as to who should lead the interview being for a

[14] Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures, Ministry of Justice, March 2013

decision using information available. Paragraph 2.26 explicitly refers to the circumstances of these 2 victims; "Children who have previously been unknown to the local children's services authority and the Police are likely to have the least understanding of the interviewing process, and of the nature of professional interventions. The way in which the purpose of the interview and the roles of the investigating team are explained to the child and their carer(s) will need to take account of the fact that they have had no previous contact with public services regarding child protection concerns about a child's safety or welfare."

5.3.47 Research published by NSPCC (2010) highlight that it is fundamental that professionals respond sensitively and create a safe space for children to talk and that disclosure should not be treated as a one off event. A study published by Coren et al (2013)[15] suggests that the on-going support and interventions in the aftermath of sexual abuse are beneficial to those young people who receive them. The findings of the study by Coren et al also found evidence of support and services being offered too late and this was also identified as a concern by Allnock et al (2009 cited in Coren et al 2013)[16]. The importance of young people getting the right support at the right time is crucial. This review has identified the importance of the social workers role in being able to offer support at the earliest opportunity and to assess wider child welfare issues and balance the prime responsibility of the Police to ascertain if a crime had been committed.

Finding 2: Joint working between Police and children's social care in West Sussex is less child focused and less effective when CID or uniformed officers respond in place of the Police child protection team.

Achieving best evidence from children who have made allegations of abuse, and providing further holistic support to them, requires a specialist skill mix of trained Police officers and child protection social workers. The review suggested that when a response to an incident is made by Police officers other the Child Protection Team, this skill mix is not brought to bear. This means that best evidence may not be achieved, and opportunities may be missed to assess wider child welfare issues.

QUESTIONS FOR THE BOARD TO CONSIDER

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- Do current arrangements lead to the best way to solve crimes and protect victims? Or may it contribute to situations where child victims feel insufficiently supported and risk such allegations not being progressed for criminal prosecution?
- Should the Police Child Protection Team be a service that is available out of hours to

[15] Coren, E. Thomae, M. Hutchfield, J. Iredale, W (2013) Report on the implementation and results of an outcomes-focused evaluation of child sexual abuse interventions in the UK. Child abuse Review Vol 22: 44-59. Wiley.

[16] Allnock, D. NSPCC Research Briefing (April 2010) Children and young people disclosing sexual abuse: An introduction to the research NSPCC

enable more effective joint working?

- Is it possible for Police to provide investigators who are trained, skilled and experienced in working with children, whenever required, as opposed to only in cases of familial abuse?
- Should Children's Social Care be a service that is available out of hours to enable more effective joint working in cases other than new urgent referrals?
- Is the WSSCB confident that ABE interviews are consistently child focused in accordance with the MoJ guidance, regardless of which branch of the Police service is involved?

FINDING 3: Investigation and assessment in West Sussex often involves Children's Social Care and Police without the sufficient involvement of other agencies, leading to a lack of full information to assist the process

5.3.48 Working effectively with young people in the context of disclosures and allegations requires forming as full a picture of their circumstances as possible, through processes such as strategy meetings, s.47 enquiries and assessments (see glossary of terms for explanation of these processes). Some of the information needed to be put together will be held by a range of agencies, both universal and specialist. It is vital that this information is gathered as part of the processing of determining risks and assessing needs.

5.3.49 Sussex Child Protection and Safeguarding Children Procedures clearly state that involvement of professionals other than Police and social care should always be considered when holding strategy discussions and meetings. Additionally, information should be obtained from other agencies when undertaking Initial and Core Assessments [and now Single Assessments[17]]. However, this review identified that this did not happen in this case.

How did the issue manifest in this case?

5.3.50 In this case, there were two main occasions when strategy meetings and assessments were made on the basis of incomplete information. This meant that social care staff were unaware of key pieces of information about John, which may have enabled them to better understand the needs of, and risks to, all the young people concerned, including the victims and John himself.

5.3.51 The period under review commenced with a strategy meeting convened to discuss the nature of the on-going allegations made against John, following earlier strategy discussions which had focused on individual victims. John had by this time denied the allegations, refused specialist assessment and the Police were of the view they were unable to progress any of the allegations. This meeting was viewed as an overdue opportunity to focus on John: review the history and what was known about John as opposed to the young people making allegations.

5.3.52 The strategy meeting involved the Police Child Protection Team as well as the social worker and manager of Children's Social Care. John had transferred to College and

[17] Single Assessment process replaced initial and core assessments in November 2013

the College was invited but a member of staff was unable to attend. Because the focus of the meeting was on John, there was a concentration on his current circumstances and hence a lack of involvement of other agencies that were, or had been previously, involved with John or his victims. The most notable omission was John's previous school where a number of his victims attended, and John attended, at the time the allegations were made. This led to a basic weakness of that meeting and any potential investigative strategy, as the school would have been able to share local knowledge and advise that the young people had a common profile. This would have enabled a wider consideration around the future safety of the victims and also of the need to consider public protection strategy.

5.3.53 John's GP was never informed of concerns about John, or asked to contribute information, despite the strategy meetings held in previous years on the victims, the one held in the review period on John and the Core Assessment undertaken following this latter strategy meeting. Indeed the GP was not made aware of any allegations or concerns until asked to contribute to this review.

5.3.54 The focus of the core assessment was to encourage John to talk about his behaviours. However, despite the 5 home visits undertaken, the Core Assessment with John lacked sufficient multi-agency involvement. The social worker was therefore unaware that the GP had made a referral to CAMHS during the period the assessment was being completed. If the social worker had known this, she would have had more information to provide an opening for direct discussion with John. In particular it would have led to her being aware of his reported suicide attempt, his request for help but subsequent lack of response to further appointments.

How do we know it is an underlying issue and not something unique to this case?

5.3.55 This review involved seven young people and a number of strategy discussions and assessments. This lack of multi-agency involvement was identified as an on-going issue that featured in all the responses to allegations about John, both before and during the period under review.

5.3.56 The Case Team members gave examples of not having been involved at that time and that this was not unusual practice. It was believed that this lack of multi-agency involvement was due to the need for prompt investigative responses; however, this would not explain the problems in this case when the meetings were not timely. Moreover this is not a relevant factor during the subsequent assessment process, when there is sufficient time to involve partner agencies.

How common and widespread is the pattern?

5.3.57 Findings from the review gave an understanding that it was the practice in West Sussex (but not nationally) at the time that strategy meetings involved primarily Police and Children's Social Care and that it would have been unusual to invite John's previous school or GP. This was explained as being around ensuring timely meetings in response to concerns [albeit this was not the case in this instance].

5.3.58 The Review and Case Team gave examples of both how practice has now changed and of continuing problems. Some in CSC reported wider multi-agency consideration given to who should be involved in strategy discussions and

meetings. Other agencies though continued to report lack of involvement especially in relation to schools being involved in strategy meetings/discussions and in relation to the south of the county.

5.3.59 Practice Standards introduced after the core assessment of John now require multi-agency checks which would include the GP and school/college. Core assessments (now child and family assessments) have to be signed off by a manager and have to comply with Practice Standards.

What are the implications for the reliability of the multi-agency child protection system?

5.3.60 The lack of involvement of other agencies at strategy meetings and in assessments may lead to a gap in understanding of what is known about the needs of a particular young person and /or the risks to others. Moreover, to be effective such information sharing has to be a 2-way process so others involved with the child and family understand the concerns. Without such an understanding, relevant information may not be identified for sharing at the time of the strategy meeting or assessment, or subsequently in the future.

FINDING 3: Investigation and assessment in West Sussex often involves Children's Social Care and Police without the sufficient involvement of other agencies, leading to a lack of full information to assist the process

Gaining a comprehensive picture of a young person, using information from a range of services, is a vital first step in the child protection process. This perhaps holds even more true when the young person is a suspected sexual offender, whose behaviour compromises the safety of other young people.

This review identified a pattern before and during the review period of the routine omission of multi-agency involvement in investigation and assessment. It raised the question whether the right balance had been achieved focusing on timely investigations and assessments with ensuring the right professionals are contributing effectively to improve the outcomes for children. Moreover it indicated a lack of understanding of the nature of 'working together to safeguard children'.

Practitioners and review team members involved have described that changes implemented in 2013 have improved such practice, such as the introduction of the Children's Access Point (CAP), consistent chairing of strategy meetings and the new single assessment[18] tool and Signs of Safety. A core principle of this approach is establishing constructive working relationships and partnerships between professionals and family members, and between professionals themselves (Bunn 2013)[19]. However, staff also point out that there is a discrepancy between the North and the South of the County.

[18] Single Assessment process has been in place since November 2013

[19] Bunn, A. (2013) Signs of Safety in England: An NSPCC commissioned report on the Signs of Safety model in child protection. NSPCC

QUESTIONS FOR THE BOARD TO CONSIDER

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- Given the challenges in changing entrenched practice is the WSSCB confident that the changes made will have been effective in embedding effective multi-agency working in investigations and assessments throughout the County; what is the evidence of this?
- Since the revisions made in Working Together (2013), can the WSSCB be assured that there is an appropriate balance between the focus on timeliness of investigations and assessments with ensuring involvement and engagement with other agencies.
- How will we know if progress is being made in this area? Would a case audit or similar be an appropriate follow-up measure?
- When other agencies are identified for involvement in investigative and assessment processes, will staff understand when it is relevant to include agencies that are no longer involved with the young person, such as previous schools?

FINDING 4: There is less clarity in West Sussex about professional child protection roles and responsibilities when the threat to children's safety is external to the family and from an alleged child perpetrator. This can impact on the quality of support offered to victims and their families and on a lack of strategy to address wider issues of public protection.

5.3.61 This finding links with Finding 1 which discusses the fact that all staff involved in this case demonstrated limited or no knowledge of a very relevant chapter in the Pan Sussex Procedures in this case. Both findings consider how the multi-agency response failed or was limited by an inability to take on board the wider issues when abuse is not within the family and is not adult on child. Finding 1 relates to lack of knowledge of the correct procedure, whilst this one stems from a lack of understanding of and clarity in the professional roles in these circumstances.

How did the issue manifest in this case?

5.3.62 The responses in relation to the allegations against John are characterised by a sense of 'professional helplessness' as described during conversations with practitioners as part of this review. Whilst those involved did not doubt that the offences had been committed they felt powerless to act to be able to intervene without a victim being prepared to make a statement and support a prosecution, or alternatively an admission of guilt and/or an agreement for treatment. In the face of a lack of evidence or admission of guilt practitioners were left without clarity about strategies for intervention and managing risk presented by the perpetrator.

5.3.63 The professional practice shown in this case suggested a lack of clarity regarding roles and responsibilities, which was evident in:

- Drift and delay in the response of social workers to being asked to provide support / undertake an assessment
- Lack of any response by agencies to the wider public protection needs of the victims and others likely to be at risk from a potential predatory sex offender
- Lack of effective challenge between staff in different agencies

Drift and delay

5.3.64 The Children's Social Care responses in this case were characterised by delay and drift during the period up to March 2013, when social workers were tasked with assessing need and providing support to the victims, following Police interviews. This was a characteristic of earlier responses, but continued into this period under review, indicating that this was not restricted to the previous era when Children's Social Care safeguarding was acknowledged to be inadequate. However there is no evidence that this was a general problem in terms of the assessment of need and provision of support to children who have been abused.

5.3.65 This delay was demonstrated on several occasions:

- following the uniformed Police response in September 2011 a strategy discussion agreed that a social worker should visit the victim within 10 days to obtain agreement to discuss his allegations with John as part of John's Children's Social Care assessment [the Police having decided on no further action]: the visit did not take place until some 4 weeks later
- there was then a further 3 month delay before the information provided on a new victim was communicated to the Police
- when a social worker was allocated to undertake the ABE interview and a core assessment in January 2013 in relation to a new victim, there was a delay in trying to make contact following the exclusion of the social worker from the ABE interview

5.3.66 Part of the problems around this stemmed from the omission of social workers from the initial responses to the victims, which would have provided them with an easier way to make a relationship with the victim, offer help and support to him and his family. **This is described in finding 2.**

5.3.67 Having missed this opportunity there was a lack of urgency in the social work responses. This is partly explained by the understandable lack of priority at that point, having missed the initial response. Moreover, because the allegations referred to past events, in contrast to those where there is imminent risk of significant harm by parents / carers. However practitioners were also describing some uncertainty in their role and responsibilities at this stage.

5.3.68 More critically a deeper understanding of the level of priority given to such responses was explained by practitioners as stemming from some discomfort with their role in offering support following Police interviews. There were three sources of discomfort:

- Firstly, the offer of advice and support needs to be made immediately or the social worker feels s/he is offering too little too late
- Secondly, there was a view that the service had little to offer when the abuse was external to the family
- Thirdly, there was uncertainty around information sharing between agencies

5.3.69 The need for immediate responses was striking in the two attempted contacts made to victims whose allegations were being investigated by Police in October 2012 and January 2013. On both these occasions the social workers were unclear about the exact purpose of their attempted contacts with the victim. In one case there was subsequent delay when management initially refused to re-allocate a new social worker following family rejection of one who got lost en route to the home and on the second a delay by the social worker in trying to make contact. In both these cases the young people or their families did not subsequently want involvement of social workers.

5.3.70 The review team was struck by the vague concept of 'support' both in terms of an intended outcome of a core assessment in this context and as an expression by social workers of their aim when allocated the work. Supporting victims (aged over 14) of sexual violence is a core responsibility for an Independent Sexual and Domestic Violence Adviser [ISDVA]; a core assessment is not necessary to access that service and, if a social work need becomes apparent, the ISDVA can refer to Children's Social Care. In fact unbeknown to the social workers in this case, the ISDVA was providing support to the victims and did do so throughout the criminal trial. This may be a better route of providing support and assessing whether there is any need for a referral to Children's Social Care.

5.3.71 The complexities around information sharing meant that the social workers (not having been involved in the initial contact and disclosure) were unclear what information provided by the Police could be shared with other agencies, other victims and with John. Without a joint investigation in 2011, the Child Protection Team handed this responsibility to social workers to progress, to return to the child making the allegation and get permission to share the information with John. This would have more easily been clarified by the Police at the outset, but reflects perhaps the Police uncertainty too.

5.3.72 There is also professional uncertainty regarding the legal basis for information sharing and disclosing to others in order to mitigate risk, in circumstances when a more pro-active public protection role is considered. The impact of this lack of clarity about what information can be shared was described by the social worker who undertook a core assessment with John and being worried about what she could and could not share with them. John and his mother also referred to not understanding why a core assessment was being undertaken.

Public protection

5.3.73 The period under review continued the pattern established earlier of focusing specifically on the needs of individual children who had made allegations, but without addressing the general risks to children with whom John would come into contact. This was particularly striking when the focus of intervention was John

himself in early 2011 when a strategy meeting was held and a core assessment undertaken.

5.3.74 There is no evidence of consideration about the risk that John posed to other children in the school, the village and the community (including a youth organisation of which he was a member), nor any strategies that could be employed by agencies/ organisations involved with John or with potential victims.

5.3.75 Partly this was associated with the lack of knowledge of the relevant procedure to follow **(see Finding 1)** and the limitations of the tools available **(see Finding 5).** But a more critical reason for this was that no-one considered it to be their responsibility to pursue this approach. Within Children's Social Care the view was that this was a Police responsibility, whilst the social workers concentrated on the safety of children within the family and the needs of identified children. The Police confined themselves to the role of criminal investigation: the officers concerned appeared to become blinkered by the lack of a substantive allegation, and did not consider how to progress matters on an intelligence-led basis, disclosing to others where necessary, both internally and externally, to mitigate risk. Conversations held with the case group indicated that Police officers might become so specialist in one area that they are unaware of the subtle changes occurring elsewhere in the service.

Lack of effective challenge between staff in different agencies

5.3.76 One of the features of this case was the good working relationships between agencies, but the lack of effective challenge to each other's practice. Examples of this are:

- The lack of effective challenge to Police by either the school or social care to the decision that there would be no further Police action to the allegations in September 2011
- Lack of challenge by school or Police at lack of use of the correct procedures which would have used either an initial child protection conference or a multi-agency meeting
- Lack of any challenge by schools at being omitted from strategy discussions
- Acceptance by children's social care in January 2012 of no need for a strategy meeting as Police view was that there was no further investigations to be undertaken
- Lack of challenge to Police to consider public protection issues: how to protect other vulnerable children in the community?

5.3.77 Practitioners' perception was that it was not appropriate to question strongly those with lead responsibility for particular functions within child safeguarding, on the basis that they are the experts and know what they are doing. This is a difficult line to judge, but safeguarding is everybody's responsibility and such professional challenge is accepted to be an important part of the way we work together. We challenge when we are confident about what must be done and/or believe something is wrong, which suggests it is a lack of confidence in this area of work which makes challenge less likely.

What makes it underlying rather than an issue particular to the individuals involved?

5.3.78 The origins of the modern child protection system originate with child abuse tragedies when children were killed by their parents / carers, most famously Maria Colwell (1973), Jasmine Beckford (1985), Victoria Climbie (2000) and Peter Connelly (2007). This has been the main focus of serious case reviews.

5.3.79 In more recent years we are increasingly considering the safety of children outside their own home, and these are considered in procedural terms under 'specific circumstances' **(see finding 1).** In recent years, serious case reviews have started to consider cases involving abuse outside the home, with reviews of recent sexual exploitation cases and some organised abuse within establishments. However, the wider role safeguarding role has not been defined in terms of the 'public protection' which was perceived largely as an issue for Police.

5.3.80 A further obstacle to considerations of public protection apply specifically to the risk being associated with a suspected child offender as opposed to an adult. Had John been convicted as an adult or child he would have been considered at MAPPA. Had he been an adult without convictions at the time the allegations were made it is possible that the Police would have considered the use of a Risk of Sexual Harm Order (ROSHO). This is a civil order granted on the balance of probabilities, where the Police adduce information to the court which indicates that an unconvicted adult presents a sexual risk to children. If granted the ROSHO places restrictions on an individual engaging in specified acts in order to safeguard a child or children in general.

5.3.81 The review team are of the opinion that there is some evidence of a mind set in West Sussex in relation to suspected child offenders, which struggles with the possible harm to a child of being labelled as a 'risk' and as a 'perpetrator of sexual offences'. This was reflected in the Police officers comment as part of this review about the need to avoid criminalising children.

5.3.82 This is coupled with the lack of any procedures to cover pro-active information sharing with other agencies, such as youth groups, local Police officers etc. as a way to protect children who have not been abused. The fears of practitioners involved in this case of committing a transgression here in terms of data protection contributed to a lack of action.

What is known about how widespread or prevalent the issue is?

5.3.83 It is not known how widespread this issue of role uncertainty is, when the threat to children arises in circumstances external to their home/family/carers, especially where the alleged perpetrator is a child. Similarly it also remains unknown how well current procedures and guidance support good practice in public protection in child on child abuse It is likely that this will be an increasing problem, as can be evidenced by the recent awareness of how we respond to concerns about sexual exploitation and about children harmed through gang culture.

What are the implications for the reliability of the multi-agency child protection system?

5.3.84 With the lack of clarity about roles and responsibilities, children who are abused by a child/ren outside their family may not get a good enough service, both in terms of potential support and with respect to a consideration of how best to protect other children who may be at risk.

5.3.85 If social workers are unclear about their purpose in such circumstances, other agencies will be so too. Social work can easily become the tasks which are not the responsibility of other agencies and the role then becomes defined by what others think the social worker should be doing. In these circumstances there is likely to be drift as individuals delay a response in favour of work that fits more clearly into their remit. Another risk is that of duplication as social workers try to do what is possibly better done by others, as happened in this case in relation to the ISDVA.

5.3.86 If there is a lack of achievable interventions available to address public protection, along with lack of clarity regarding which is the responsible agency to lead and co-ordinate the available actions, it is likely that insufficient attention will be given to this part of the safeguarding response.

FINDING 4: There is less clarity in West Sussex about professional child protection roles and responsibilities when the threat to children's safety is external to the family and from an alleged child perpetrator. This impacts on the quality of support offered to victims and their families and on a lack of strategy to address wider issues of public protection.

Practitioners are unclear about their roles and responsibilities in circumstances when serious sexual allegations are made about a child, but there is not sufficient evidence collected to progress to a prosecution and the child her/himself denies the allegations. Without clarity professionals feel helpless and their responses are muddled and subject to delay.
Whilst partly this arose in this case due to lack of awareness of the relevant procedure [see Finding 1], there is a need for a framework in these circumstances that considers matters of public protection and information sharing to protect others.

Issues for the Board to consider:

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- Is there clarity about the role of the WSSCB and its constituent agencies in relation to public protection when a child themselves poses the risk to other children
- What are the roles of Police and Children's Social Care in the public protection responsibilities that need to be addressed in circumstances of a suspected child offender?
- Is there a need for a forum to consider the risks of children who pose a risk to other

children (along the lines of MAPPA)?

- Do we need to clarify information sharing arrangements within the procedures for child on child abuse? (see considerations in finding 1)
- The need to clarify the legal position on the sharing of information about an unconvicted person
- Is there clarity about the role of social workers in the provision of support to children and families who make allegations about other children when there is no criminal investigation?
- Is there knowledge within other agencies of the ISDVA role?
- How should the service pathways operate so as to avoid duplication of input by social workers when an ISDVA is involved?
- Is the lack of effective challenge observed in this case a reflection of the uncertainty of roles with regard to the circumstances of this case, or is it a more general cultural issue within safeguarding work in West Sussex?

Finding 5: Complex database arrangements within Children's Social Care and Police, and the reliance on individuals to insert and maintain linkages, prevent quick and accurate identification of all relevant history in circumstances when there are a large number of victims involved

5.3.87 The ability to establish the history of a case quickly and accurately is an issue for both Children's Social Care and Child Protection Teams and any response should take this history into account.

5.3.88 This case has suggested a vulnerability whereby the proliferation and design of electronic databases did not support workers to 'make links' between the different children involved. This led to an overreliance on individual workers to remember the links between individuals, which is unreliable and unsustainable in the long term, and means that patterns of offending and behaviour were not detected.

How did the issue manifest itself in this case?

5.3.89 In the circumstances of this case, every time there was a new allegation it should have been considered within the context of previous information about the victim(s) and the abuser – this would involve being able to easily access ALL previous referrals, the enquiries undertaken and the outcomes of each.

5.3.90 There were a number of instances in this case in which electronic databases did not facilitate identifying and understanding links between the different victims of abuse. This prevented professionals from gaining an accurate picture of John's offending.

5.3.91 Conversations with the case group suggested that the overview of the case was held by individuals, rather than in a durable, and shared way as part of the database. This suggests a vulnerability whereby electronic databases do not support workers to 'make links' between different children involved in the same case. The first database used by Children's Social Care did not allow linking whereas Frameworki does, although in this case links were not made on the system until

early 2013. This leads to an overreliance on individual worker's memories or manual intervention to maintain this information; this is unreliable and unsustainable in the long term, and means that patterns of offending and behaviour are not detected.

5.3.92 Within Children's Social Care, TM1 referred to herself as holding the history of the case in her head and that this was disrupted when the service was re-organised with eight offices moved into three hubs in 2010. This meant that teams ceased to have the same local geographical links but also that the management oversight of cases was strengthened. SW1 talked about only knowing about victims 1 and 4 and not 2, 3 or 5 although all had been implicated by the time she did a core assessment in 2011.

5.3.93 When the allegations about victims 7 and 8 surfaced in later 2011, the DS in the Child Protection Team referred to John having "been seen" as if he had been interviewed regarding these allegations, when in fact he had been interviewed in June 2010 about allegations made in 2009, but not about subsequent allegations. It is not clear why the DS thought this, and s/he is currently off sick so we are unable to establish the reason for this misunderstanding. SW3 talked about personally adding linkages between John and all his victims in late 2012, when the full extent of John's offending became clear.

5.3.94 We saw, in the information (MOGP1) sent in September 2011 from a SOLO to CID and on to Child Protection Team and then to Children's Social Care, that only the information gathered from interview was included. There was no history or linkage to other allegations. The DS in Child Protection Team reviewed the MOGP1 as one of many that day and did not search the databases to find the history. Given that she accepted the SOLO's view that there was no assault this was reasonable at the time, but even an outline of previous history would probably have alerted her to the need to reconsider the need for further action. Arguably the plethora of databases impeded any potential impetus to review the whole case.

What makes it underlying rather than an issue particular to the individuals involved?

5.3.95 Children's Social Care transferred from paper files to an electronic database known as eRIC in 2007. Previously, all the earlier files/papers relating to a case would be given to a social worker when the case was re-opened. This worked when cases were "linear" involving members of a family but less well when families had fragmented or when parents had several partners, or when several families/children were involved.

5.3.96 Electronic records provide the potential for bringing out links between cases, but the history locally has not made optimum use of this technical possibility. In Children's Social Care, social workers are faced with 3 means to establish a history: paper files, eRIC and Frameworki. Introduced in 2007, eRIC was not a success and Frameworki was commissioned to replace it in early 2011. Records were transferred from eRIC but while some are clearly labelled others require a worker to open them before it the content is clear; this is time consuming and liable to cause omissions. Meanwhile, paper records were dispersed into a number of locations and poorly catalogued or curated until a project to set up a records

management service introduced an efficient retrieval system and dedicated storage in 2011. During much of the review period the retrieval of paper records was seen as somewhat hit and miss and as a consequence tended to be overlooked.

5.3.97 It was a shock to the review team to find that the Child Protection Team have eight databases as well as paper records. And, while Frameworki contains records migrated from eRIC, the Police databases are all stand alone. All the Child Protection Team Officers who took part in conversations referred to the number of databases as an impediment to efficient working, whether because of the time needed to search all the relevant databases or the possibility of missing information or both.

What is known about how widespread or prevalent the issue is?

5.3.98 This is an issue which is the status quo for both Police and Children's Social Care although both agencies believe their current database (Niche in the Police and Frameworki in Children's Social Care) will prove more durable than previous systems. Review team members in both agencies could quote examples from their own practice of situations where important information had been overlooked due to the difficulty of finding it.

5.3.99 There is a view within the Police that Sussex Police have more databases than other forces, but it seems likely that this issue is replicated to a lesser or similar extent elsewhere. Children's Social Care in West Sussex was much later than most local authorities to transfer to electronic recording and may be unusual in having made a further change of provider. However, the issue of paper records being overlooked and a working assumption that the history is on the database, in the experience of members of the review team, does happen.

What are the implications for the reliability of the multi-agency child protection system?

5.3.100 The implications of the difficulty inherent in researching the history of inter-locking cases with potential linkages, are that both the Police and Children's Social Care can be over-reliant on the memory of individuals. This was tacitly recognised by members of the case group who talked about holding John "in mind" or needing a "hook" to aid their ability to maintain a memory. For one worker, the hook was having been to school with someone (apparently unrelated) who shared John's surname. This works as well as it does because West Sussex has a core of people who stay put and hold collective memories, a fact also referred to by members of the case group.

5.3.101 The risk of patterns of behaviour or of relationships going unnoticed is inevitably higher where records are hard to access. It must also be frustrating for agencies which have shared information which has got lost on Police or Children's Social Care records. The potential for this to undermine child protection through the undetected movement of abusers into new families must be high.

5.3.102 The focus of children's social work has traditionally been to work with the child within their family. This is changing due to the reasonable expectation that child protection includes issues outside of the family including sexual exploitation, missing children, trafficking and gang-based activity. All are or are likely to be

group-based activities requiring the ability to map people and locations in such a way that the information can readily be updated and shared. The scoping of child sexual exploitation is already demonstrating the difficulties in the use of IT.

Finding 5: Complex database arrangements within Children's Social Care and Police, and the reliance on individuals to insert and maintain linkages, prevent quick and accurate identification of all relevant history in circumstances when there are a large number of victims involved

In cases involving multiple children making allegations of abuse against the same person, it is important that workers are able to consider this information as a whole, in order to gain a sense of the overall pattern and seriousness of the alleged offending behaviour. This review found that proliferation and design of electronic databases currently hinders this from occurring, meaning that important information about the 'bigger picture' in a case is lost.

This is a significant obstacle to safe practice and was the subject of actions in two previous serious case reviews, Family E and Family F.

The Family E serious case review called for a mechanism and standard for the review of repeat child protection referrals/incidents Police IMR S.9 rec.2). The action was not signed off as the recommendation was linked to the development of Child Protection Team electronic family files. In order to finalise the transfer of records a major upgrade was necessary to the force's main computer system and this could not be achieved within the action plan timeframe.

The Family F serious case review recommended that child protection information should be centrally and electronically recorded and managed (Executive Summary 7.6). Although Niche is now providing a mechanism to manage and record information in the Child Protection Team, it would seem that the previous data storage systems still prove a block to good practice

Issues for the Board to consider:

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- There have been changes in the IT systems in both the Police and Children's Social Care: is the Board satisfied that the new IT systems can be sufficiently responsive to the need to collate and map information about networks of known and suspected abusers and victims?
- What actions have been taken since the last serious case review to improve the routine functionality of these systems so that they make it easier for individuals to remember to make the appropriate links?

Finding 6: There is a lack of effective assessment and intervention tools in West Sussex for children who are abusers, but deny allegations and are not able to be prosecuted.

5.3.103 The needs of young people who sexually abuse are complex. There is growing awareness and acknowledgement of the incidence of sexually harmful behaviour by children and young people. The establishment of a National Youth Justice Board following the Crime and Disorder Act (1998) provided an opportunity to address the development of services for young people who sexually harm in a more strategic and consistent manner.

5.3.104 The Assessment, Intervention and Moving On (AIM) initiative was developed approximately 10 years ago to create a more coordinated approach across agencies and enable the establishment of a range of services to meet the needs of assessing and supporting young people and their families. This initiative was adopted by West Sussex and launched widely. The route into the service was via the Criminal Justice route or the 'concern route' (identified as behaviours beyond normal exploration and experimentation and generating concerns). A range of tools for assessment were developed for assessment and intervention and professionals (social workers, teachers, school nurses) were trained to undertake assessments at an 'early intervention' stage of concerns being raised.

5.3.105 This case shows that in circumstances when the abuser rejects such an assessment via the 'concern route', professionals are left relatively helpless in their ability to assess and intervene effectively. The assessment tools within Children's Social Care are no replacement as they do not address the risk the young person poses to others.

How did the issue manifest in this case?

5.3.106 In 2010 following further investigations into allegations made against John that he denied, a referral was made by Children's Social Care to the Assessment and Treatment Centre (ATS) for an AIM assessment. As none of the allegations made against John progressed to a criminal justice route, he was referred via the 'concern' route. Initially John gave consent for an assessment but subsequently withdrew this and the referral was unable to be progressed. This led to difficulties for professionals in knowing what to do next.

5.3.107 A core assessment was viewed as the only option available but this process does not involve the use of any risk assessment tools and although the social worker built a relationship with John, the assessment was completed without any multi-agency involvement. Members of the case group stated how they felt frustrated and powerless; the social worker stated '*I used all my social worker skills to get him to access ATS'.*

5.3.108 Throughout the review, the AIM process was referred to as being an important opportunity to have assessed John and to discuss his behaviours and whether there may have been an alternative earlier route into such an assessment. However, many of the review team were not familiar with the AIM process and others noted that in the last few years there has been an increasing reliance on ATS to undertake screening as well as specialist assessment and treatment.

How do we know it is an underlying issue and not something unique to this case?

5.3.109 The Review and Case Team represent agencies across West Sussex. It was not viewed as an issue specific to one area.

5.3.110 West Sussex has in place procedures in respect of Children who harm other children (Section 8.7) and includes specific direction on how to respond to an allegation of sexual abuse; however the procedures have not been developed to the extent of other areas in respect of multi-agency working with AIM which include assessment tools e.g. 'The Traffic Light Tool' (Blackpool LSCB). This may be a reason why the service is not so well known and appears to have lost momentum. Additionally, it is noted in finding 1 that procedures were not followed in respect of having a multi-agency meeting.

How common and widespread is the pattern?

5.3.111 The details of this case are unusual and provide a new area to focus child safeguarding work. It is not commonly reported to have a child perpetrator with multiple same sex victims.

5.3.112 Criminal Justice Joint Inspection (2013)[20] in a report examining multi-agency responses to children and young people who offend, identified that multi-agency interventions often lacked coordination. Initial denial of sexual offending proved to be a major barrier to the provision of effective interventions. Additionally, relevant to the findings of this review, the report found where health and education had contributed effectively to the assessment process, some '*excellent interventions'* were delivered by those workers.

5.3.113 It is believed to be a national concern that professionals are unsure how to adequately assess cases of harmful sexual behaviour in children. The research and evidence base for assessment and intervention is clear but there are concerns about a lack of a coordinated response. Community Care (12th September 2013) raised the concerns that the Government had been urged to implement a national strategy on working with children and young people who sexually abuse, amid claims that cases are getting more serious and social workers lacked confidence when assessing and intervening. The report highlighted a national strategy had been in place since the 1990s but never fully implemented.

What are the implications for the reliability of the multi-agency child protection system?

5.3.114 Smith et al (2013[21]) in a project undertaken for the NSPCC, identify the nature, extent and significant negative consequences of harmful sexual behaviour for the

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[20] Examining Multi-Agency Responses to Children and Young People who sexually offend (February 2013) *A Joint inspection of the effectiveness of multi-agency work with children and young people in England and Wales who have committed sexual offences and were supervised in the community.* A joint Inspection by HMI Probation, Care and Social Services Inspectorate Wales, Care Quality Commission, Estyn, Healthcare Inspectorate Wales, HMI Constabulary, HMI Prisons and Ofsted

[21] Smith, C. Bradbury-Jones, C. Lazenbatt, A. Taylor, J (2013) Provision for young people who have displayed harmful sexual behaviour. NSPCC

victims and perpetrators and recognise this as an important issue for policy development and research investigation.

5.3.115 Failure to engage should be recognised as a risk factor and to be a trigger for considering wider public protection and disclosures. The review team gave consideration to the need for a 'Youth MAPPA' process.

5.3.116 The report acknowledges that in the last decade there has been a movement towards greater understanding of the issue of harmful sexual behaviour by children. The study aimed to explore the provision for young people who have displayed harmful sexual behaviour and found an absence of clear guidelines may leave local authorities grappling with the practicalities of assessment and intervention.

FINDING 6: There is a lack of effective assessment and intervention tools in West Sussex for children who are abusers, but deny allegations and are not able to be prosecuted.

The needs of young people who sexually abuse are complex. There is growing awareness and acknowledgement of the incidence of sexually harmful behaviour by children and young people. Although the establishment of a National Youth Justice Board provided an opportunity to address the development of services for young people who sexually harm in a more strategic and consistent manner, there still appears local and national concerns about a lack of a coordinated response. The issues are compounded and wider public protection issues increase, when the young person fails to engage.

The service has in recent times worked hard to engage young people who are initially reluctant to attend and to provide consultation to the professional network. What is not known is the extent to which these changes have made an impact made an impact.

QUESTIONS FOR THE BOARD TO CONSIDER

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- The WSSCB to seek an evaluation report/outcomes report of the ATS Service
- Is there a need in West Sussex to develop a multi-agency procedure in respect of Assessment, Intervention and Moving On (AIM) that will be incorporated into the Pan Sussex procedures or develop the existing procedure?
- Does the single assessment need to include assessment of the risk posed by a child/young person, when s/he is the subject of such allegations?
- Is there a need for the WSSCB to consider the development of a 'Youth MAPPA' to address the wider public protection and assessment needs of young people who sexually harm; particularly those who deny allegations and fail to engage?

Finding 7: The current Child & Adolescent Mental Health Service (CAMHS) needs a reliable system to evaluate the need for liaison with children's social care and /or pro-active follow-up of non-engagers

5.3.117 The principal role of Child and Adolescent Mental Health Services is to provide therapeutic services to young people with emotional and mental health problems. Some young people's difficulties may have safeguarding implications. This could be for the young person themselves – for example, in the case of suicidal ideation - or for other individuals. This case has suggested that there are insufficient links between CAMHS and safeguarding processes in children's social care, meaning that:

- For young people already known to Children's Social Care, the fact that a CAMHS referral has been made may not be known, and
- Young people not already known to Children's Social Care, who choose not to engage with CAMHS, may continue to present a risk to themselves or other people.

5.3.118 This finding focuses on the responsibilities of CAMHS to make contact with other agencies. The lack engagement by Children's Social Care with agencies including CAMHS has been explored in Finding 3.

How did the issue manifest in this case?

5.3.119 The events in this case suggested that, despite the relevance of their work to safeguarding issues, West Sussex CAMHS can become disconnected from wider safeguarding processes.

5.3.120 During the period of the Core assessment, John was referred to CAMHS by a GP. John reported feeling very low due to a sexual harassment case and that he had dropped out of college. The referral also contained information regarding a previous suicide attempt. There was no information to indicate the involvement of any other agencies, and this was not checked out before the appointment.

5.3.121 John was seen and assessed within 2 weeks of referral, well within the timescales for assessment using the CAPA (Choice and Partnership Approach)[22] In line with good practice, he was seen alone for part of the appointment and it was assessed that he fitted the remit for the emotional wellbeing (EWB) service and a therefore a further appointment was offered with the same clinician. It was understood that he was alleged to have sexually harassed others and not that he was being sexually harassed. Additionally he self-reported a suicide attempt, substance misuse and suffering bouts of aggressive behaviour.

5.3.122 John did not attend the next appointment and this was not followed up further by the CAMHS team, apart from contacting the GP. The GP was concerned that John

[22] The choice and partnership approach (CAPA) is an initiative that was introduced to CAMH services across the country as a way of managing the traditionally long waiting lists to access CAMHS in order to meet national targets regarding waiting times for CAMHS appointments. The CAPA is a way of enabling CAMH services to see all young people within 8 weeks of referral in line with government targets. The young person has an initial Choice appointment in order for the clinician to undertake a brief assessment of the presenting difficulties and assess the suitability of the young person and their family for CAMH services or for signposting to other services.

did not attend the follow up appointment and wrote to him three times. No further action was taken by the GP or CAMHS regarding any safeguarding implications of John's non-engagement.

5.3.123 The appointment at CAMHS took place while SW1 was completing a core assessment and trying to find ways to get John to talk about his sexually predatory behaviour. SW1 was unaware of the referral to CAMHS including the self-reported information about the attempted suicide, the alleged sexual harassment, the aggressive behaviour and substance misuse.

How do we know it is an underlying issue and not something unique to this case?

5.3.124 Since John was seen at CAMHS the paperwork for the Choice appointment now has a prompt to ask whether people are known to other agencies; this relies on self-report but is a prompt for the clinician to have this discussion with the family and to follow up as necessary. Whilst this would certainly mark an improvement in the potential multi-agency involvement, its reliance on self-reporting remains a weakness in the safeguarding system, albeit one that is likely to be consistent nationally with the way information sharing arrangements operates.

5.3.125 For young people who choose not to engage with CAMHS services, there is a process to follow as explained in the Active Engagement policy[23]. This includes active follow up by the practitioner for follow up appointments and assessment of the situation with other members of the team and with family. The extent to which there is or is not any routine and systematic following of the policy is not at all clear within CAMHS, nor who is responsible for ensuring this occurs. A further complication is that the clinician offering the Choice appointment is generally responsible for signposting, but not for follow up.

How common and widespread is the pattern?

5.3.126 The views expressed within the review by practitioners and review team suggested that there is a perception that what had occurred here was not unusual and part of a wider issue of a disconnect between CAMHS and other safeguarding agencies. However, there was no concrete evidence provided to support this.

What are the implications for the reliability of the multi-agency child protection system?

5.3.127 The issues with which young people present to CAMHS may have safeguarding implications, either for their own safety or for others. This case has suggested that in West Sussex there is a lack of consistent and routine systems and processes within CAMHS to:

- Check available databases prior to the appointment so as to establish if a child is known to Children's Social Care and make contact if s/he is known
- Flag up young people to Children's Social Care who are referred to the service with concerns which have safeguarding implications (e.g. suicide, substance and alcohol misuse etc.), but then choose not to engage

[23] Active Engagement incorporating Did Not Attend (DNA) Management Policy & Procedure, Sussex Partnership NHS Foundation Trust 02.05.12

5.3.128 This means that, for children already known to Children's Social Care, there is the potential for CAMHS referrals not to be made known, and useful information not shared. For children not known to Children's Social Care who choose not to engage with CAMHS, there is the potential for safeguarding issues to remain unaddressed.

5.3.129 A failure to attend health appointments has been a consistent feature of serious case reviews, highlighted by Brandon et al (2009[24], 2010[25]). The issue of missed appointments has been further explored by Powell and Appleton (2012)[26] who argue for reconceptualising child and young person did not attend (DNA) to 'was not brought' (WNB). They propose the shift in terminology would lead to positive interventions to safeguard and promote the welfare of children that go beyond missed appointments to a move towards the child-centric practice described by Munro (2011). This approach considers the significance of the non-attendance from the young person's perspective, assessing their possible vulnerability and the risks to their health and well-being from what is known. A number of important questions are posed to consider and prompts consideration to communicate with other services to seek further information about the child and family i.e.:

- Why the young person was not brought?
- What is the risk to the child's health and well-being?
- What information do we have about this child?
- Is there a Common Assessment Framework / Lead Professional?
- Is the child known to social care services?
- What am I going to do about it and what action should I now take?

5.3.130 Considering what was known from undertaking the Choice assessment and when risks are identified, a more robust and child centred approach to non-attendance needs to be considered. This will avoid working in isolation.

5.3.131 It has been noted that Sussex partnership NHS Foundation Trust have a robust Active Engagement Policy. The purpose of the policy is to set out guiding principles for staff regarding achieving best possible service user engagement. Implementation of the policy should reduce the incidence of people not attending appointments and ensuring the wellbeing of those service users who do not attend (DNA) appointments.

[24] Brandon M, Bailey S, Belderson P, et al. (2009) Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-2007. London: DCSF.

[25] Brandon M, Bailey S and Belderson P (2010) Building on the learning from Serious Case Reviews. A two-year analysis of child protection database notifications 2007-2009. London: Department for Education.

[26] Powell, C. Appleton, JV. Missed health care appointments: reconceptualising 'Did Not Attend' to 'was not brought'. A review of the evidence for practice. Journal of Research in Nursing 2012 17:181

FINDING 7: The current Child & Adolescent Mental Health Service (CAMHS) needs a reliable system to evaluate the need for liaison with children's social care and /or pro-active follow-up of non-engagers

The issues with which young people present to CAMHS may have safeguarding implications, either for their own safety or for others. This case has suggested that:

- There is a lack of guidance around the need (or not) to make contact with children's social care for information prior to the initial Choice appointment of vulnerable young people;
- There are no consistent systems for following up young people about whom there are safeguarding concerns (e.g. suicide, substance misuse, aggression, accusations of sexual harassment) and who choose not to engage, including guidance when to involve Children's Social Care

This means that, for children already known to Children's Social Care, there is the potential for CAMHS referrals not to be made known, and useful information not shared. For children not known to Children's Social Care who choose not to engage with CAMHS, there is the potential for safeguarding issues to remain unaddressed.

QUESTIONS FOR THE BOARD TO CONSIDER

The WSSCB has prepared a separate document in response to the following considerations: this describes the actions that are planned to strengthen practice as a response to the findings of this serious case review.

- The need to involve the CAMHS service fully in the multi-agency safeguarding system and be confident of a consistent approach regardless of the different professional background of the clinician, to establishing if prospective patients are known to children's social care and whether liaison is needed
- The need for a consistent approach to DNAs in CAMHS, regardless of the individual clinician, which involves review of what is known, checking of available databases, multi-disciplinary evaluation of risk prior to closure, recording the rationale for decisions including which agencies are/are not informed
- Should there an audit to examine the extent to which CAMHS is linked into the multi-agency safeguarding system?

6 CONCLUSIONS

6.1.1 In an era of decreasing resources nationally, the member agencies of West Sussex Safeguarding Children Board are facing up to new or previously unmet needs including child sexual exploitation in all its forms: exploitation online, by gangs and groups, by supposed partners and by other children. What this review has illustrated is that if agencies respond to a previously unknown situation by doing the same as they have always done, the outcomes for the children involved are too often poor.

6.1.2 There is a deceptive safety in following a well- trodden path through safeguarding procedures and it is not surprising that practitioners should hold on to what they know when faced with a situation which is unfamiliar. We are not advocating that any practitioner should ignore procedures; quite the reverse. Instead practitioners should use the full range of procedures and work reflectively, using the outcomes they aim to achieve as the starting point for actions and using processes within the safeguarding system to support the achievement of goals.

GLOSSARY OF TERMS AND ABBREVIATIONS

ABE	ABE interviews are those that follow the guidance provided for interviewing children and other vulnerable people in 'Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses' (Ministry of Justice 2011)
AIM	Assessment and Intervention, Moving On (Assessment used by the ATS).
ATS	Assessment and Treatment Service (Service for children who are a potential sexual risk to other children)
CAMHS	Child and adolescent mental health service
CAP	Children's Access Point (Children's Social Care)
CAPA	The choice and partnership approach (CAPA) that is adopted in CAMHS means that the young person has an initial Choice appointment in order for the clinician to undertake a brief assessment of the presenting difficulties and assess the suitability of the young person and their family for CAMH services. At the assessment, a decision is made as to whether the young person requires CAMHS or another service.
CID	Criminal Investigation Department
CPT	Child Protection Team (Police)
CSC	Children's Social Care
Core assessment	'An in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context'. (Framework for the Assessment of Children in Need and their Families DH 2000
DC	Detective Constable (Police)
DS	Detective Sergeant
eRIC	Electronic Recording of Information on Children (database in use before FWi)
EWB	Emotional Well Being
FWi	Frameworki (Local Authority electronic database since February 2011)
ICPC	Initial Child Protection Conference
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MI	Management Instruction
MOGP1	Memorandum of Good Practice – Form 1. An external and internal form used by Sussex Police to record contacts with children and young people.
NFA	No further action
ROSHO	Risk of Sexual Harm Order
s.47 enquiry / Section 47 enquiry /child	s.47 enquiry refers to section 47 of the Children Act 1989 which gives local authorities the duty to 'make, or cause to be made, such

protection enquiry	enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare' when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm
SCR	Serious case review
SARC	Sexual Assault Referral Centre
SOLO	Sexual Offence Liaison Officer
Signs of Safety	The Signs of Safety model is a tool intended to help practitioners with risk assessment and safety planning in child protection cases. See *Bunn, A. (2013) Signs of Safety® in England: an NSPCC commissioned report on the Signs of Safety model in child protection. London: NSPCC.*
Single Assessment	Single Assessment process is the assessment process used in children's social care, which was introduced in November 2013 and replaced initial and core assessments
SOPO	Sexual Offence Prevention Order
Strategy meeting / discussion	A strategy discussion is held when there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. This may be following a referral and initial assessment or at any time during an assessment where a child is receiving support services if concerns about significant harm to the child emerge. The purpose of the strategy discussion is to enable the Children's Services' department, Police and other relevant agencies (e.g. health services, schools) to share information, make decisions about initiating or continuing enquiries under s. 47 of the Children Act 1989, what inquiries will be made and by whom, whether there is a need for action to immediately safeguard the child, and what information about the strategy discussion will be provided to the family. Decisions will be made regarding the provision of any medical treatment, how to handle inquiries in the light of any criminal investigation and whether other children affected are in need or at risk.
TM	Team manager