LEARNING FROM A SERIOUS CASE REVIEW

Child GG

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The SSCB commissioned a Serious Case Review in relation to a 16 year old child known, for the purposes of the review, as Child GG.

Synopsis

Child GG was placed in police protection in December 2015 and subsequently was voluntarily accommodated, i.e. became looked after, with parent's agreement due to concerns that the child was sexually exploited by adults.

Main Themes

The main themes identified in this review are as follows:

1. There seemed to be lack of recognition among professionals of the risk of CSE as well as 'drift'. Risk indicators around CSE were present since 2014. Child GG's parent had also been raising concerns during that time. However, the emphasis of service provision was around mental health and substance misuse. Concerns around Child GG being sexually exploited were formally discussed at six multi-agency meetings in the six months preceeding Child GG being taken into police protection in December 2015.
2. The need for coordination of services and especially the multi-agency response to CSE. There was evidence of lack of coordination in service provision, especially around referrals and thresholds for specific services to Child GG and her family.
3. The importance of relationship-based practice with children who have been involved in child sexual exploitation (CSE). This involves the recognition that some children involved in CSE find it difficult to accept that they are being exploited and consequently do not engage fully with agencies. These children seem to apprieciate and respond well to consistent, clear and structured relationships.
4. The importance of professionals' understanding the impact of conditions such as ADHD, ASD etc on children's behaviour. This includes impulsivity and difiiculties in understanding the impact of their behaviour and the consequences of their actions. It is therefore essential to secure professional

expertise to support the understanding of professionals and to support best management of challenging behaviour.

5. The need to consider and minimise the impact of a child's challenging behaviour, especially one who is suffering from the control, fear and influence of external perpetrators, on the family, including on younger siblings.
6. The need to avoid blaming or holding children suffering from CSE responsible for the abuse.
7. The importance of skilled, informed and reflective supervision and management oversight.
8. The importance of professionals sharing information and of proactively seeking information when there are concerns. It is equally important that all relevant professionals are invited to meetings where information-sharing and decision making is taking place.
9. Assessements took too long to complete and were outside timescales, however, when completed, they were of good quality.

Good Practice

- Professionals had an understanding of Child GG's vulnerabilities and risks of CSE.
- Although frequently excluded, schools kept Child GG on roll and when permanently excluded, arrangements for alternative provision were made taking into consideration the family's wishes to avoid use of online provision to minimise risks to the child.
- There was evidence of relationship-based practice by the Family Support Services (at the time Youth Support Service), Surrey Police (SPOC) and Catch-22.
- When assessments were completed, they were of good quality.
- Evidence of improvement in disrupting perpetrators.

Recommendations for the SSCB

1. Assess and if necessary, improve the extent of current knowledge about CSE and the features and manifestations of adolescent behaviour, ADHD and ASD so that professionals can distinguish between these.
2. Review the skills of professionals in building positive relationship with children particularly those who professionals find it challenging to engage and the extent to which professionals are knowlegeable about what assists in building relationships – honesty, trust, time, persistence, structure and consistency. If this is found to be inconsistent or staff lack confidence, the SSCB should provide multi-agency training to address this.
3. Audit the extent to which effective, relfective supervision and management oversight and decision making is implemented across agencies, acknowledging that supervision means different things to different agencies.
4. Audit the extent to which children involved in or at risk of CSE are no longer blamed or held responsible and that records are respectful about the child and their family.
5. Ensure that the significant improvements across all services and arrangements such as triaging and MAECC are embedded.
6. Raise awareness of CSE with taxi drivers, hotels, after school clubs, youth groups, park wardens and sports clubs.
7. Satisfy itself that professionals understand that information sharing involves joint responsibilities for providing and seeking information and that the Board's escalation policy is understood and effectively used.
8. Map the range of specialist and voluntary services that are provided and commissioned to assist children, not jus tthose involved in CSE and where necessary re-commission or commission services to fill the gaps. Whils this work is being undertaken, knowledge about what services provide, their thresholds and the referral pathways should be widely shared.

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