Overview report

SERIOUS CASE REVIEW

Child GG

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1. INTRODUCTION

Background to the review

This report of a Serious Case Review (SCR), examines the responses, support and services provided to a child referred to as Child GG and her family, from January to December 2015 when Child GG was in her mid-teenage years.

2. THE REVIEW

2.1 Elaine Coleridge-Smith, the Surrey Safeguarding Children Board (SSCB) Independent Chair agreed to commission an SCR on the 30th March 2016, because of concerns that Child GG had been the subject of child sexual exploitation (CSE) and there was learning to be derived, as to the effectiveness of services to support her.

2.2 A Serious Incident Notification was sent to OfSTED on the 19th May 2016, in accordance with statutory procedures.

2.3 The review was conducted under the statutory guidance of 'Working Together 2015' and applied the principles of learning and improvement from that guidance which states:
"SCRs and other case reviews should be conducted 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 organisations to act as they did;*
- *Seeks to understand practice from the viewpoint of the individuals and organisations involved at that 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 findings"*

2.4 All the agencies that had been involved with Child GG and her family were asked to complete a record of their involvement, with comments and this was collated into a combined chronology. A list of these agencies is attached at Appendix 1. The information used to undertake this analysis was derived from a combined chronology, two learning events with practitioners and managers, telephone interviews with professionals who were unable to attend the practitioner events or from whom more information was needed, meetings with Child GG and her mother and a review of key documents.

2.5 The SSCB SCR subgroup approved a methodology that included agencies adding comments to their chronologies, this worked well in some aspects, although some professionals interviewed found that this did not easily enable them to answer the key issues identified in the terms of reference. Any areas they could not address were explored in interviews by the Lead Reviewer and at the practitioner and manager's events.

2.6 I was asked to undertake the SCR as the Lead Reviewer, produce an Overview Report, facilitate events to gather the views of managers and practitioners who were involved with Child GG or the services delivered at the time and individual, follow up interviews.

2.7 I am independent of the local authority and all the agencies involved in this review, having not had any previous involvement with them, apart from undertaking a SCR in respect of another case. I have extensive experience of undertaking SCRs, chairing LSCBs and inspecting and reviewing local authority services to children and young people.

2.8 The review was overseen by a SSCB SCR Review Panel chaired by Amanda Boodhoo the designated safeguarding nurse who was not involved in the case. Excellent support has been provided to the review by members of the board's staff team.

2.9 The terms of reference for the review are attached at Appendix 1. In line with Government advice it seeks to evaluate *why* things happened rather than focussing on what happened.

The involvement of the family

2.10 I met Child GG and her mother and am very grateful for their contribution to the review and their reflections on what had worked well and what had not. Some of these views are incorporated into the report.

3. CONTEXT

3.1 Surrey is a large county council in the south of England in which approximately 256,400 children and young people under the age of 18 years live. This is 22% of the total population in the area. It is a relatively affluent area, approximately 10% of the local authority's children are living in poverty. The proportion of children entitled to free school meals in primary schools is 8% (the national average is 15%) and in secondary schools it is 7% (the national average is 14%). There are comparatively lower numbers of children from minority ethnic groups (13% of all children living in the area), compared with 22% in the country as a whole.

3.2 On 31st March 2015, 5735 children had been identified, through assessment as being formally in need of a specialist children's service i.e. they were children in need of support or protection, this is an increase from 4,538 on 31st March 2014.

3.3 On 31st March 2014, 925 children and young people were the subject of a child protection plan. This is an increase from 925 on 31st March 2014.

3.4 On 31st March 2015, 995 children were being 'looked after' by the local authority (a rate of 31 per 10,000 children). This is a reduction from 925 (33 per 10,000 children) on 31st March 2013.

3.5 The local authority operates nine children's homes. Seven were judged to be 'good' or 'outstanding' in their most recent Ofsted inspection and two were judged to be 'adequate'. The previous inspections of services for 'looked after' children in September 2010 judged services to be 'adequate'. The Ofsted inspection of the local authorities (Children's Services) child protection arrangements, in September 2012, judged services as 'adequate' and the Ofsted report, published in 2015, regarding the inspection of services for children in need of help and protection, children 'looked after' and care leavers, judged the service to be 'inadequate'. The local authority is subject to regular monitoring by Ofsted, of the improvements made.

3.6 Surrey Police were the subject of an HMIC vulnerability inspection in July 2015 and were graded as 'inadequate'. A subsequent review of progress, by HMIC in April 2016, identified that: there had been significant improvement in all areas although progress in developing and embedding the MASH was slow; the inspectorate advised that the progress needed to continue in order to embed all the improvements.

4. CHILD SEXUAL EXPLOITATION

4.1 Ten years ago, very little was known or understood about CSE. Over the last eight years it has been the subject of much debate and improvements in practice, particularly since statutory guidance was issued in 2009 and it became an area to be reported on by Ofsted and the high-profile cases in Derby, Peterborough, Rotherham and Oxfordshire, raised the extent of the problem.

4.2 CSE is a form of child sexual abuse but it differs in an important respect which is that grooming is involved, in person or via the internet and social media; it results in children being inappropriately influenced to perform sexual acts **in return/exchange** for something-praise, gifts, drugs etc. and the perpetrators to also receive the sexual gratification they want. Children under 16 years of age are not legally able to consent to sexual intercourse; sexual activity with a child or causing, inciting a child to engage in sexual activity or meeting a child following sexual grooming and exploiting children are criminal offences; children who are the subject of CSE are completely innocent of any involvement and are not in any way responsible, despite what may be perceived as a transactional arrangement. Children do not always perceive CSE as a crime and can feel that they are in control of what happens to them.

4.3 Definitions of CSE vary across the UK and N Ireland and, informed by a growing understanding of the subject have led to the DfE consulting on a new definition for England.

5. NARRATIVE OF KEY EVENTS

5.1 This section does not list all the events and interactions that took place, it highlights significant events, examples of interactions and opinions drawn from an integrated multi-agency chronology.

5.2 Although the review covers the services that were provided in 2015, previous events that are relevant are included as they evidence early concerns in relation to Child GG's difficulties in engaging with professionals, school attendance problems, aggressive behaviour, self-harm, drug use and sexual activity with older males.

5.2.1 Child GG was referred to Child and Adolescent Mental Health Services (CAMHS) in 2012 and was intermittently involved in services until April 2014. She had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), oppositional behaviour and Autistic Spectrum Disorder (ASD). She was aggressive towards her mother and her peers and sometimes harmed herself by cutting and scratching her body. She was described as non-compliant with her medication and assessment and did not agree with the diagnosis, she did not want to attend CAMHS and therefore did not engage with the service offered.

5.2.2 In 2013, there were concerns that Child GG was not attending school regularly, and she experienced difficulties with another child at school, which was reported to the police by her mother.

5.2.3 In April 2014 School 1 completed a Common Assessment Framework (CAF) which sought to address Child GG's self-esteem by a referral to an Attendance and Engagement programme and providing support to Child GG and her mother to support Child GG to take her medication and understand the risks of self-harm and how to reduce this.

5.2.4 In the same month, Child GG's mother reported that her daughter wanted to meet a 16-year-old boy who she had met on Instagram. Her mother had refused as Child GG was only 13 years old and she had become verbally abusive to her mother and had assaulted her. The police visited the family and supported Child GG's mother's view and identified the potential risk of CSE, they did not undertake research on the 16-year-old boy to ascertain his vulnerability, or the extent of his contact with other children.

5.2.5 Concerns increased in 2014 about Child GG engaging in sexual activity with the 16-year-old boy and on 16th May 2014, information was appropriately shared with Children's Services and health.

5.2.6 In July 2014 Child GG was referred to the Alternative Learning provision at a short stay school, this application was not successful however. The same month an application to another Short Stay School (School 2) was made, agreed in November, and was planned to continue until March 2015.

5.2.7 In December 2014, Child GG was fitted with a contraceptive implant. The file records of the GP and the local provider of community health services do not indicate that consideration was given to the fact that Child GG was only just 14 years old.

5.2.8 On 27th December 2014, following a fight at home, evidence of Child GG using cannabis extensively and associating with older people was identified, a referral was made to the Multi-Agency Safeguarding Hub (MASH) highlighting the risks of CSE and the potential impact on Child GG's half-brother Child H; a child and family assessment was agreed, but no information was gathered by the police, in relation to the people with whom Child GG was associating or who were supplying her with drugs.

5.2.9 On 28th December 2014, the case was allocated to a social worker who had been qualified for one year.

Key events covered by the period under review

All the following dates occurred in 2015.

5.2.10 On 2nd January, a police report was shared with the school nurse at School 2 concerning Child GG's physically aggressive behaviour to her mother, the school nurse did not contact Child GG, as she was only on the mainstream school role to secure her education, whilst she was at the Short Stay School and was not under the care of the school nurse.

5.2.11 On 4th January, Child GG's mother informed the school that her daughter was living with her aunt, there was no information as to the reason or the

length of time this arrangement would last, this information was reported to Children's Services but not placed on the school's child protection file.

5.2.12 On 6th January, the social worker and a family support worker visited the family home to begin the child and family assessment. Child GG was seen alone by the family support worker who felt there was a risk of family breakdown and a referral to the Extended Hours Service (EHS) and the Youth Support Service (YSS) was planned.

5.2.13 On 7th January, the social worker consulted CAMHS who had discharged Child GG in April 2014 when she had not engaged in their service, CAMHS did not offer a service following the consultation with the social worker, despite the concerns expressed about Child GG's difficulties but they recommended a referral to a drug use agency to address her cannabis use.

5.2.14 On 9th January, Chid GG's mother contacted a local Hospital saying her daughter was out of control and was smoking cannabis.

5.2.15 On 15th January Child GG was excluded from school.

5.2.16 On 16th January, a multi-agency meeting was held including the social worker and Child GG, it was agreed she would be referred to the YSS and her placement at the short stay school would be extended on a permanent basis.

5.2.17 On 19th January, in supervision between the social worker and her manager, issues of Child GG's violence and engaging in under-age sex were identified and a referral to EHS was agreed but it was felt that the concerns did not meet the threshold for child protection enquiries or intervention. On the same day, the police visited the family, due to reports of aggression by Child GG towards her cousin; Child GG's mother again reported her drug use and sexual activity. No information was subsequently gathered in relation to the risks of CSE and Children's Services have no record of this visit or the incident referred to.

5.2.18 On 22nd January, the social worker referred Child GG to YSS for Child in Need support.

5.2.19 On 23rd January, Child GG was excluded from school for one day.

5.2.20 On 26th January, the police visited the home as Child GG was reported to be out of control, she was taken into custody but not prosecuted as this was not considered to be in the public interest, Child GG was seen as the cause of the problems without consideration of the wider vulnerabilities in relation to CSE. The same day, the Criminal Justice Psychiatric Liaison Service (CJPLS) reported that Child GG was compliant with medication (information held by Children's Services does not support this view), was living at home and did not need further support from their service.

5.2.21 On 27th January, the social worker was informed of the above aggressive incident but not of the arrest or the involvement of CJPLS, there is no evidence that this was discussed with a manager to consider a strategy meeting to assess the risk to Child GG and Child H. This was contrary to procedures but appears to have been decided as a child and family

assessment was being undertaken. The same day the family support worker visited Child H, the records do not indicate whether the violence towards him by his half-sister was addressed or his needs assessed and planned for.

5.2.22 On 28th January, the local hospital undertook a health assessment as part of the statutory assessment process for a statement of special educational needs, a copy of the letter of assessment was sent to the school, the GP, and Child GG's parents but not to Children's Services.

5.2.23 On 30th January, Child GG was excluded from school.

5.2.24 On 2nd February, Child GG's mother informed the social worker of the school exclusion the previous week and that she was not coping with her daughter. The social worker does not appear to have discussed this with her manager or reviewed the increasing risks to Child GG and Child H. The situation was not discussed with Dr 2 in relation to Child GG's ADHD and ADD and how Child GG could be encouraged to take her medication and so reduce the aggressive aspects of her behaviour and the attendant risks to her mother and half-brother.

5.2.25 On 3rd February, Child GG was excluded from school.

5.2.26 On 4th February, School 2 informed the Children's Services duty social worker that Child GG had made explicit statements about how many men she was having sex with, who she wanted to have sex with and her use of cocaine and LSD. Later the same day, School 3 contacted the same duty worker to say they were concerned about the pressure that Child H was under due to his half-sister's behaviour. There is no evidence that these issues were discussed with a manger or a strategy meeting was considered.

5.2.27 On 5th February, Child GG was excluded from school.

5.2.28 On 9th/10th/11th February Child GG was excluded for three half days.

5.2.29 On 11th February, a meeting was held between School 1 and School 2 due to Child GG's behaviour, lack of engagement in education and her vulnerability when she was not in school.

5.2.30 On 12th February, Child GG's mother reported to the family support worker and the police that her daughter was missing from home and had been arrested for shop lifting. A strategy meeting was requested by the police although Children's Services have no record of this request. On the same day, School 1 contacted School 2 due to the number of exclusions (12) at the centre and concerns about Child GG having inappropriate sexual images, smoking in school and leaving school without permission. There is no evidence that safeguarding actions were taken about the sexual images.

5.2.31 On 13th February, Child GG was involved with YSS due to the shop lifting offence and the subsequent Youth Restorative Intervention Order, however, CAMHS were not involved, due to Child GG's previous attitude and lack of engagement.

5.2.32 On 21st February, the police informed the social worker that Child GG had thrown a knife at her mother. This was not raised with a manager and a strategy meeting was not convened. The chronology also highlights the lack of direct work with Child GG or Child H by Children's Services.

5.2.33 The EHS, received a referral and asked for further information which was not received within timescales. There was a view that EHS would not work with families where YSS was involved.

5.2.34 On 22nd February, a referral had been made to YSS. However, at the initial handover meeting the YSS social worker was informed that the case was going to an Initial Child Protection Conference (ICPC) and YSS would not be required to provide Child In Need support. Child GG was not made the subject of a child protection plan at the conference but the Child in Need work did not go back to YSS. This would appear to be because the social worker was considering referring to the EHS and the young people's substance misuse service and could not refer to EHS if Child in Need support was being provided by the YSS.

5.2.35 On 26th February, Child GG was excluded from school.

5.2.36 On 2nd March, Child GG was excluded from school.

5.2.37 There is no record of the strategy meeting referred to in the police entry in the chronology (as above) in the Children's Services entry for 12th February or of it taking place within statutory timescales.

5.2.38 On 4th March, Child GG's mother informed the family support worker that her daughter had assaulted her, was receiving gifts and had been visiting Nottingham and London to meet older men. This information was passed to the social worker and the Assistant Team Manager (ATM) but the records are not clear whether the ATM reviewed the incident. There is no record that a strategy meeting was convened or consideration given to receiving Child GG into care, with the agreement of her mother.

5.2.39 On 4th March, Child GG was excluded from school.

5.2.40 On 5th March, the social worker and family support worker witnessed Child GG assaulting her mother in front of Child H. A strategy meeting had already been agreed but did not take place until five days later.

5.2.41 On 9th March, a strategy meeting was held and included a representative from the local health provider of community services. It was agreed a joint section 47 enquiry would be carried out by Children's Services and the police. Child GG would be referred to the mental health preventative day service and the young people's substance misuse service. The CSE register would be checked to ensure Child GG's name was included and support would be provided for Child H.

5.2.42 On 11th March, Child GG was excluded from school.

5.2.43 On 12th March, the mental health preventative day service did not accept the referral, as in their view Child GG's school placement was not in jeopardy and they thought other services including EHS, could provide support. The same day, Child GG was admitted to Accident and

Emergency at the local hospital after she had sent a text to her mother to say she wanted to harm herself and had been taking drugs. Following an assessment by CAMHS Child GG was discharged the following day with her agreement to being referred to the young people's substance misuse service.

5.2.44 On 17th March Child GG was excluded from school.

5.2.45 On 23rd March Child GG was excluded from school.

5.2.46 On 30th March, an ICPC was held. School 2 and Children's Services attended. The GP was unable to attend the meeting but he provided a report, although this did not include information about Child GG's sexual history. Relevant health information was not shared with the ICPC Chair and the school nurse was unable to attend. The report from the social worker highlighted the full range of Child GG's difficulties and recommended that she and Child H should be made the subject of Child Protection plans however, at the meeting the social worker changed her opinion as she was advised at the meeting that the involvement of the mental health preventative day service would reduce risks to Child GG and the family. Following a split decision, it was agreed that a Child in Need plan would be agreed and referrals to the mental health preventative day service, EHS and YSS would be explored again.

5.2.47 On 31st March, the social worker referred Child GG to the young people's substance misuse service who requested confirmation of Child GG's consent to this.

5.2.48 On 8th April, the social worker completed a child and family assessment, it had been due to be completed on the 28th January 2015.

5.2.49 On 13th April, Child GG was excluded from school. It was also decided that Child GG would not be allowed to continue attending School 2 after the Easter holidays, due to her behaviour.

5.2.50 On 14th April, Child GG's mother informed the social worker that her daughter was frightened, as a friend has discovered she was not 17 years of age. The social worker was also told that Child GG continued to self-harm; this information was not uploaded onto the central recording system until 17th June so it could not be accessed by other staff.

5.2.51 On 15th April, EHS requested further information, following their receipt of a second referral. The same day, a crisis call was received from Child GG's mother who said her daughter was receiving threatening texts, it was decided she would go and live with her aunt again; this information was also received from the police who visited but there is no evidence of a response by Children's Services and there was a delay in uploading the reported concerns until 22nd July 2015.The police did not seek further information on the person Child GG said was providing her with drugs.

5.2.52 On 20th April, a Team around the Family meeting was held in school, it was agreed that concerns would be shared with Special Educational Needs managers to determine whether an education assessment was required.

5.2.53 On 21st April, the social worker referred Child GG to the mental health preventative day service as agreed at the ICPC on 31st March and discussed with the ASD worker about whether she could offer Child GG support, the ASD worker stated that Child GG's needs were beyond her expertise and as Child GG was living with her grandparents in another local authority area it would not be appropriate anyway.

5.2.54 On 23rd April, the first Child in Need meeting was held, the social worker inappropriately chaired it, instead of an ATM. There was no review of the recommendations made at the ICPC.

5.2.55 On 24th April 2015, the police identified that the above joint visit had not taken place and recorded this again on 14th May, adding that it would appear a single agency visit had been made by Children's Services and they had decided that Child GG was not 'at risk'. It was agreed that the police should undertake their own interview, on 17th June 2015 the police identified that they had not done so and a visit was made the same day.

5.2.56 On 27th April, the young people's substance misuse service responded, within timescales, to the referral they had received.

5.2.57 On 5th May, an Education, Health and Care Needs Assessment (EHCN) was requested by a paediatrician.

5.2.58 On 8th May, School 1 informed School 2 that the mental health preventative day service had not accepted the referral for their involvement.

5.2.59 On 14th May, the social worker made the third referral to EHS as the mental health preventative day service had not accepted the referral to them.

5.2.60 On the 21st May, EHS advised the social worker that they would close the referral to them so that the social worker could pursue a referral to the mental health preventative day service which was more likely to be accepted if they did not attend discussions.

5.2.61 By the 27th May, Child GG returned home and was saying she did not want to be involved with the mental health preventative day service, as she had previously agreed, as she would know people who also attended. Child H was reported to be more subdued following his half-sister's return home.

5.2.62 On 3rd June, Child GG and her mother were seen at a doctor's clinic in the local hospital and follow up appointments was made for Child GG to be seen at the ADHD clinic.

5.2.63 On 4th June, the YSS worker informed the family support worker that Child GG had been visiting people in Nottingham, Leeds, Manchester and Ireland. No consideration of a strategy meeting appears to have taken place. The same day, a meeting at School 1 discussed whether Child GG could attend the mental health preventative day service. The mental health preventative day service appeared unclear as to whether she would meet their criteria and said they would require a referral from EHS so it was agreed Child GG would first be referred to EHS.

5.2.64 On 5th June, the family support worker saw Child GG with her aunt but the records make no reference as to the appropriateness of this arrangement, how the parenting role was shared with Child GG's mother and how safe she was.

5.2.65 On 8th June, the young people's substance misuse service made significant efforts to contact Child GG.

5.2.66 On 10th June, Child GG's mother informed the GP that her daughter wanted her contraceptive device removed and she was worried that this would increase her daughter's vulnerability. Child GG was seen by the GP and stated she could manage any risk to her as she" always asks partners whether they have been tested first". This surprising statement by a 14-year-old does not appear to have been explored by the GP.

5.2.67 On 15th June, the ATM requested that a Child in Need meeting was recorded as having been held on 4th June, there is no evidence that this meeting had taken place in Children's Services' records but other agencies record in their chronology that a "multi-agency meeting" had taken place (which was probably the Child in Need meeting) but there were no actions for their service. The meeting discussed Child GG's difficulties and noted that an Education, Health and Care Plan (EHCP) had started and would be completed by September.

5.2.68 On 15th June, Child GG was discussed at a Missing and Exploited Children Conference (MAECC). Three actions were agreed (including a referral to Sliding Doors) but not allocated to a named professional and the records of the meeting do not include the discussions or an analysis of risk. On the same day, Child GG informed the young people's substance misuse service that she did not want their support. The meeting was not used to address and resolve the number of referrals to a range of different support services.

5.2.69 On 17th June, police records evidence that CSE risk assessments/safeguarding, action and trigger plans and system markers to highlight high risk cases were added to their information systems.

5.2.70 On 18th June, Child GG's mother informed the family support worker and the police that she had again been assaulted by her daughter who was continuing to visit a 17-year-old male in Nottingham and on occasions drinking alcohol heavily when in a public place. The records do not indicate that a strategy meeting was considered and the risks to Child H do not appear to have been assessed. On the same day EHS accepted the referral made by Children's Services.

5.2.71 On 24th June, the police appointed a single point of contact (SPOC) in relation to the CSE risks, to facilitate information and provide a consistent response.

5.2.72 On 26th June, Child GG was reported missing from her aunt's house having gone out to meet a man she had met on the internet. There was no consideration of a strategy meeting and Children's Services records do not evidence that the missing children procedures were followed, for example by meeting Child GG on her return, to gather information and ensure she was safe.

5.2.73 On 2nd July, Child GG was allocated to the EHS service.

5.2.74 On 9th July, concerns about Child GG's risky behaviour were shared with the local health provider of community services but not responded to by a triage assessment, in accordance with organisational guidelines.

5.2.75 On 20th July, the second MAECC was held, the records note the involvement of EHS and that Child GG had again been referred to the mental health preventative day service, even though this had been done on a previous occasion, the records do not include the difficulties of engaging Child GG in services and how this could be resolved. But it agreed that a Safeguarding Advisor should provide advice to Child GG's parents.

5.2.76 On 24th July, the EHS service was again unable to engage Child GG, this difficulty does not appear to have been reviewed.

5.2.77 During August, there was a continued lack of engagement by Child GG and concerns about her behaviour and the risks to her continued to increase however, the records indicate that Child GG had not been seen by the EHS social worker since June 5th.

5.2.78 On 10th September, the referral to the mental health preventative day service remained pending. Alternative education provision was arranged and on-line learning was identified as a possibility.

7.2.79 On 24th September, a locum social worker requested a strategy meeting, the manager of EHS advised that this request may not be accepted as Child GG's mother was fully engaged in supporting her daughter.

7.2.80 On 25th September, the third MAECC was held and recognised that the safeguarding plans were not working and a strategy meeting should be convened as Child GG was at high risk of CSE. Other than this action, it is unclear what the MAECC plans were. On the same day, Child GG refused to attend Sliding Doors as she thought she would be embarrassed by other young people who she knew, being there.

5.2.81 On 5th October, Child GG was reported missing and found intoxicated in London. No consideration was given to convening a strategy meeting or liaising with Surrey Police. On the same day, the alternative education provision worker had a good meeting with Child GG and following the meeting she appropriately reported her concerns about Child GG's involvement in sexual activity, with inappropriate people.

5.2.82 On 14th October approval was given to produce an EHCP.

5.2.83 On 19th October, the EHS manager identified that agreed actions had not been completed by EHS and should be considered by a strategy meeting. On the same day, a MAECC was held and it agreed that a strategy meeting should be convened to review the plans for Child GG.

5.2.84 On 26th October, a strategy meeting was held but the minutes were not agreed until 25th November which was considerably outside timescales. A decision was made for Children's Services to instigate section 47 enquiries

as a single agency i.e. not including the police, and if Children's Services thought the thresholds were met, to convene an ICPC. It was also noted that Child GG and her mother were unwilling to engage with the EHS, YSS and the mental health preventative day service and adult mental health services were unwilling to offer support to the family as EHS has been unsuccessful in engaging the family.

5.2.85 On 29th October, management of the case was transferred to a different ATM.

5.2.86 On 2nd November, the case was transferred to new social worker within the Referral, Assessment and Intervention Team (RAIS). A robust assessment was recorded highlighting the significant risks of CSE, Child GG's lack of engagement in services and her mother's difficulties in managing her daughter's behaviour.

5.2.87 On 4th November, Child GG was seen by her new social worker, following initial hostility, she engaged well with the worker and talked about her life and her wishes.

5.2.88 On 9th November, School 1 informed the social worker that Child GG was not accessing her Special educational needs (SEND) provision and asked the social worker for advice about how this could be improved.

5.2.89 On 18th November, a MAECC was held, records show that the number of missing episodes had reduced but Child GG was continuing not to engage with the police. It was agreed the police should pro-actively identify the adults involved with Child GG, through social media.

5.2.90 On 23rd November, Child GG assaulted her mother.

5.2.91 On 25th November, section 47 inquiries were completed 23 days outside timescales. On the same day, Child GG assaulted her mother and the police undertook a second Domestic Abuse, Stalking and Harassment (DASH) assessment (to identify the level of domestic abuse risk to Child GG's mother and to child H).

5.2.92 On 28th November, Child GG was arrested for the third time, following the assault on her mother on the 23rd November. Following her arrest, her mobile phone was examined and a number of sexual messages from a male were identified.

5.2.93 On 3rd December, a second referral to the young people's substance misuse service was received and responded to within timescales.

5.2.94 On 3rd December, a strategy discussion was held with the RAIS ATM and a single agency section 47 enquiry was agreed, to be undertaken by the police.

5.2.95 On 4th December, the police arrested an adult male on suspicion of grooming with a view to CSE, following examination of electronic equipment no evidence of inappropriate or illegal activities were found.

5.2.96 On 7th December, a MAECC was held, a summary of concerns and Child GG's lack of engagement with services was recorded. Child GG was

identified as at continuing high risk of CSE and it was agreed that YSS and Sliding Doors would be offered to her.

5.2.97 On 9th December, Child GG was placed in police protection and a foster care placement was requested from Children's Services. The police also informed Children's Services of the extensive number of inappropriate images, texts, information about drug use, attendance at sex clubs, pictures of Child GG with large amounts of cash, countless references to drugs and the identification of 24 adult males with whom Child GG had had contact. The police also stated they were taking action against Child GG's mother for wilful neglect, although it was subsequently decided that she had not committed an offence and her bail conditions were cancelled. Children's Services decided a legal planning meeting would be held, to consider whether the thresholds for a Secure Accommodation Order were met for Child GG, it was also agreed that the case would be managed under the LSCB's Complex Abuse Process and a meeting on the 10th December would be chaired by a Senior Manager.

5.2.98 On 10th December, a complex abuse strategy meeting was convened which identified a considerable number of concerns and actions to address these, including seeking consent from Child GG's mother for her daughter to be voluntarily accommodated i.e. placed in 'care' and if this agreement was not obtained, consideration being given to an Emergency Protection Order and the removal of Child GG from home. The same day, with her mother's consent, Child GG was placed in a foster home and a place in a children's home in another local authority area was sought to move Child GG out of the area as soon as possible.

5.2.99 On 17th December, the police visited Child GG at her residential placement, she disclosed that she had been raped by an 18-year-old man and she agreed to an Achieving Best Evidence (ABE) interview, but in March 2016 it was decided that the evidence she gave did not meet evidential thresholds.

5.2.100 On 22nd December, an ICPC was held, Child GG was not placed on a child protection plan as she was a 'looked after child' and the subject of statutory LAC planning arrangements.

5.2.101 On 23rd December, a senior manager agreed that Child GG's care should be managed through a Care Order and the Public Law Outline process should be used to apply for this.

5.2.102 On 19th January 2016, Child GG's name was removed from the list of children discussed at the MAECC.

5.2.103 In January 2016, disclosures by Child GG led to the arrest of a number of adults, both male and female, due to concerns about them sexually exploiting children. It was subsequently decided that in none of the cases was there insufficient evidence to support prosecutions for criminal offences.

6. ANALYSIS

6.1 This section considers the quality of practice, actions, decisions, missed opportunities and improvements referenced in the terms of reference.

Risk assessment and decision making

What were the key points for assessment, decision making and effective intervention in this case and what was the quality and timeliness of decision-making?

6.2 Overall, the quality and timeliness of assessments (including strategy meetings to assess new information and emerging risks) was poor.

6.3 During 2014, there were clear issues of concern in relation to Child GG's non-school attendance, aggression, self-harm, under-age sexual activity with an older boy, drug use and lack of engagement with services and taking her medication. Although individual agencies, school, CAMHS, health and the police responded and a CAF was completed, there should have been an earlier referral to Children's Services, so that a multi-agency approach could have reviewed the information and agreed an integrated approach to support Child GG and her family and explore the risks presented by a named male.

6.4 Throughout 2015, there were several opportunities to assess and re-assess the situation and plan effective interventions but several of these were missed. The children and family assessment which commenced in January 2015, took four months to complete, well outside the 2013 statutory guidance, "Working Together to Safeguard Children" timescale of 45 days. I have reviewed the assessment and am satisfied with the content and exploration of risk and identification of need.

6.5 On 21st February, 4th March, 18th June, 26th June, 19th August, 25th September and 5th October new information and increasing concerns should have led to the consideration of strategy meetings with partner agencies, to identify the level of risks to Child GG. There appears to have been a lack of compliance and understanding about strategy meetings and when they should be convened. On 24th September, an inappropriate decision was made not to convene a strategy meeting because Child GG's mother was fully co-operating with the plans for her daughter. On another occasion, in January 2015, it was decided not to convene a strategy meeting as a child and family assessment was being undertaken. This was not in accordance with statutory guidance which states "*A strategy discussion can take place following a referral or at any other time, including during the assessment process".* On some occasions, when strategy meetings were held, they were outside SSCB timescales, the agreed actions were not appropriate and the record of decisions and actions were not completed for some time, which meant there was a lack of clarity as to what actions agencies should take and some actions were not implemented. In April 2015, the police noticed that a joint visit with Children's Services, agreed at a strategy meeting in February, had not taken place and it appeared Children's Services had made the visit on their own. It took until 17th June for the police to carry out their visit. On 7th December, a strategy meeting decided that section 47 enquiries should be made only by Children's Services, which given the extensive involvement of the police, was not appropriate.

6.6 When strategy meetings were held, the children were not always seen and information as to the plan was not shared with Child GG's mother.

6.7 In terms of other assessments, a paediatric assessment in 2012 diagnosed ADHD, oppositional behaviour and ASD. Child GG did not agree with the diagnoses and did not engage with support or take her medication. In March 2015, Child GG was assessed in hospital and the chronology indicates that a thorough assessment was completed and identified the complex issues and Child GG's resistance to co-operating; an appropriate plan was also completed and included an offer of a further assessment, when and if, Child GG felt able to engage. During the review, comments were made that, following the diagnosis of ADHD, Child GG looked for information about the medication she had been prescribed on the internet. Having seen the possible side effects, she became anxious and did not want to take it, there seems to have been little exploration of the reasons for her decision.

6.8 There was some understanding of Child H's needs and of the impact his sister's difficulties had on him, but it was the view of RAIS at the time that he was receiving services from other agencies. A lack of exploration and oversight of what these services were, contributed to the lack of consistently effective planning until late in 2015, when he became the subject of a Child in Need plan.

6.9 It is not known whether an assessment of Child GG's mother was made as part of the child and family assessment which, given her pivotal role in safeguarding her daughter, would have been appropriate. In December 2015, it was agreed that a parenting assessment should be undertaken through the Public Law Outline process, the purpose of this was to determine whether Child GG could safely return to live with her mother. The chronology ends before information as to whether this assessment took place could be recorded.

6.10 The decision not to make Child GG the subject of a child protection plan was based on the fact that Child GGs mother was fully cooperative and doing all she could to protect her daughter, whilst that decision was not inappropriate it was not reviewed in light of the fact that the Child in Need planning arrangements were ineffective in co-ordinating and delivering an integrated plan. At the time, there was a lack of clarity about the arrangements for children in need of statutory support with several services undertaking this work. This was identified as a failing by Ofsted in August 2015.

Were the risks of sexual abuse and/or sexual exploitation to Child GG while missing from home and school, effectively considered and responded to appropriately?

6.11 Agencies were aware of the risks to Child GG of CSE from an early stage, however, as the above section states, new information was not always responded to appropriately with strategy meetings and assessments but services, particularly the police who frequently visited the family, were responsive, particularly to Child GG's mother's concerns.

6.12 Child GG spent a lot of time out of education, despite the efforts of schools to provide her with appropriate education. There were many occasions when Child GG was excluded from school, due to her behaviour, although she was never permanently excluded, but is not clear that an assessment of her vulnerability or the risks presented by being excluded was considered in relation to the exclusions although there was recognition of the fact that when not in school or at home she may be at risk of CSE.

6.13 There is less evidence that when Child GG was living with her aunt any assessment of her care or the management of risks was thoroughly evaluated, Child GG was not the subject of a child protection plan nor was she a 'looked after child' so the local authority had little authority to impose a plan however, in late 2015 a written agreement was produced to clarify the arrangements.

6.14 The chronology provides very little evidence that when Child GG was staying with her aunt, steps were taken to ensure she was in receipt of education, apart from a visit by the family support worker on 4th June 2015. The chronology evidences that this took place but not whether education was discussed. Resources to support Child GG, who was identified as a child with social, emotional, and mental health difficulties were agreed on the 19th August 2015. On the 10th September the chronology identifies that the EHCP to address these needs was still awaited and on the 14th October, the chronology notes that the draft plan was waiting to be written but approval had been given for the EHCP to be written by the panel. In December 2015, the SEND Team Manager was seeking for an improved SEND plan to be completed as Child GG was not accessing this provision. Child GG's mother found the lack of consistent education very frustrating.

6.15 Children who are not in school are entitled to up to 25 hours a week of education. This is dependent on their circumstances. In February 2015, in recognition of the fact that Child GG had already had 12 fixed term exclusions School 1 contacted School 2 to suggest that Child GG should access education via virtual learning environment (VLE). In May 2015 School 1 again contacted School 2 to say that the referral to the mental health preventative day service had been turned down and as Child GG was not attending School 2 she was not receiving any education and due to her inappropriate use of the internet Child GG's mother would not support her receiving education via a home computer; in June 2015, the school instructed staff to send work to Child GG's home and to do so in paper versions as she had no access to a computer; in September as part of alternative education provision, support on-line learning was again considered a possibility but was subsequently provided in person.

What was the quality of multi-agency risk assessments and were Child GG's mental health needs assessed and treated appropriately?

See above.

Was the level of vulnerability and risk to Child GG fully understood by the different services within an organisation and effectively communicated between different services and partner agencies?

6.16 Most agencies understood Child GG's vulnerability and risk in terms of social, physical, mental, emotional, and sexual issues and inter-agency communication by telephone and email was good. There were some occasions when health information was only shared with health agencies and some inter-agency communication was not evidenced in the records, although it may have happened. There was less use of multi-agency meetings where professionals met face to face; as previously stated, strategy meetings were not effectively managed and the Child in Need plan was not managed well. At the first ICPC there were differences of opinion about whether the children were at risk of significant harm and required a child protection plan and MAECC did not, until late in 2015, provide an effective forum for multi-agency information sharing, assessment, and planning.

6.17 The YSS social worker took the opportunity presented by the SCR to reflect on her practice; whilst she was confident that she had supported Child GG effectively, establishing a good rapport and encouraging and supporting better engagement with the social worker, she is of the view that, with the benefit of hindsight, she could have contributed more to the CSE risk assessment and could have requested that she was invited to meetings with other agencies such as the education planning meetings, this reflection is commendable professional practice.

Is there any evidence that a focus on other risks impacted negatively on the identification of possible child sexual exploitation?

6.18 The records do not indicate that a focus on other risks had a negative impact on the possibility of CSE. Although the understanding of CSE was at a low level early in 2015, it increased during the year. The challenges inherent in the case; Child GG's difficulty in engaging with services and taking her medication; her frequent absences from home and school and; spending time living with her aunt, faced agencies with frequently changing demands which they had difficulty keeping up with.

How effective was the Missing and Exploited Children (MAECC) procedure and its implementation in this case? What was known about child sexual exploitation at the time?

6.19 There were seven MAECC meetings that discussed Child GG's situation between July 2015 and January 2016. MAECC was at a very early stage of development in early 2015 and there was a lack of distinction between child protection and CSE issues with professionals insufficiently informed to make the distinction.

6.20 At the practitioner's SCR event, professionals commented that some agencies such as health, including the GP, were not informed that a child was being considered at MAECC but this has considerably improved with lead CSE nurses in Safeguarding Teams attending MAECC and triage meetings or contributing by sending reports (however, GPs are still not informed when children go missing or are excluded from education).

6.21 There was also a lack of understanding about what agencies could do, individually or collectively. This led to ineffective risk assessments and plans, there are comments in the chronology that indicate MAECC was not making any difference.

6.22 There was no separate consideration of the risks presented by alleged perpetrators and what actions could be taken to gather information and deploy effective disruptive approaches.

6.23 There have been improvements, MAECC is now more effectively chaired with Children's Services and the police chairing separate sections to focus separately on the victim and the perpetrator however, the decision not to continue considering Child GG at MAECC when she became a 'looked after child' was, in my view premature.

6.24 There is also a greater focus on CSE by the police and Children's Services, local triage panels have been introduced to discuss victims and perpetrators at an early stage, share information and put early support in place. The police Safeguarding Investigation Units (SIU) now include a specialist CSE team that focusses on medium and high risk cases and a CSE Single Point of Contact (SPOC) carries out extensive research on any adult suspects and pro-actively address any concerning behaviour by warning them, disrupting their activities and where appropriate, arresting them. Practitioners and managers who attended the SCR event commented very positively on these new arrangements.

6.25 In addition, education now contribute to MAECC meetings through the attendance of the Education Welfare Officer, education have also put additional resources into CSE and have improved multi-agency communication which has led to the earlier recognition of CSE and referrals to Children's Services and the triage process.

However, there is still the need to improve the knowledge and understanding of professionals in relation to what constitutes CSE.

6.26 Some professionals I interviewed, commented on the huge increase in resources deployed in relation to CSE, the considerable increase in specialist staffing roles and the amount of time that is devoted to CSE each week, they wondered whether this is always proportionate to the scale of the problem and the impact on other types of child abuse for example physical abuse. One professional said that attending MAECC takes too much time, too many cases are discussed and the fact that not all attendees have prepared for the meeting means they take too long. In their view the same children are repeatedly discussed because the outcomes have not been positive and the same things are repeatedly tried with a lack of evaluation of the plans; they felt the discussions and plans should be more outcome focussed to make a more efficient use of the time.

Were there any issues in communication, information sharing or service delivery, within, between or across localities and services, including services commissioned jointly by the agencies? Agencies should make particular reference to the arrangement for escalation of concerns within and between agencies to more senior officers.

6.27 One of the key features of this case was the difficulties experienced by agencies in co-ordinating integrated support services particularly with the mental health preventative day service, the EHS and CAMHS. There was a lack of understanding about what services each could offer and under what circumstances they would accept referrals, which wasted the social worker's time and led to delays in effective arrangements being put in place. For example, at the practitioner's event it was commented that Children's Services and education had held the view that Child GG should be offered support from the mental health preventative day service but they were told that if a child is the subject of a child protection plan they would not be eligible, they therefore decided that she should be assisted as a Child in Need so that EHS could become involved and then she could access the mental health preventative service, however EHS would not accept her as she was engaged with YSS. Given the positive relationship the YSS worker established with Child GG there would have been benefit in the case continuing to be held by the service under child in need and challenging other agencies regarding the coordination of services.

6.28 Professionals who attended the SCR events commented that there needs to be a review of specialist and support services in Surrey to identify gaps and duplications and ensure that together they provide services that can meet the needs of all children at risk of CSE.

6.29 In completing the chronologies, agencies made no reference to opportunities to escalate concerns or use the SSCB escalation policy; a procedure that was agreed in 2014.

When different services within agencies became involved with Child GG, was her family history sufficiently explored and understood to enable these services to fully understand the vulnerabilities and risks?

6.30 The assessments completed by social workers in April and November were good and considered the history of the family, but in respect of other agencies, there was insufficient information in the comments attached to the chronologies, to evaluate whether they all shared an understanding of the history however, this does not mean it had not been considered. Education identified that it had been difficult to work out what

had happened in this case, due to the lack of recording of child protection concerns by their staff, this has been addressed and decisions and actions are now recorded and designated Safeguarding Leads meet to discuss cases of concern and identify individual risks and annual audits in schools now include record keeping as part of their evaluation.

When Child GG and her mother failed to engage fully with services provided, were services sufficiently persistent in promoting engagement or were there missed opportunities? Did the services within agencies have effective procedures to deal with non-engagement or non-attendance and were these procedures followed

6.31 There is evidence that services tried hard to engage Child GG but this proved difficult. Many children involved in CSE do not recognise that they are at risk and are reluctant to engage with services although non-statutory services are sometimes more attractive to them. An added difficulty was that Child GG did not accept that she needed to take her medication for her difficulties, had she been able to, her behaviour and attitude may have been different.

6.32 The information available does not enable me to address the issue of procedures to deal with non-engagement or non-attendance and I cannot see that these are addressed in the SSCB procedures.

Did the services effectively communicate with Child GG in a way that she could fully understand? Were there any missed opportunities to communicate more effectively, particularly in respect of her Special Educational Needs?

6.33 The records evidence that some people were able to engage well with Child GG. For example on the 8th October 2015 the alternative education provision professional was able to enable her to share her difficulties and concerns and to divulge significant information, the chronology also comments that the police SPOC established a good relationship with Child GG and the young people's substance misuse service used different approaches to communicate with her. When she was involved with YSS, in addressing the offence of theft through the Youth Restorative Intervention Order, she did engage well and although the consequences of not doing so may have been a factor in her engagement, she was more fully involved with the YSS workers than with some others and this was due to the structured way the worker dealt with her, the regularity and frequency of contact and the worker's ability to communicate effectively; this view was supported by Child GG when I met her.

Management oversight/supervision and accountability

Was there sufficient management accountability for decision-making? What was the quality of supervision? Were senior managers or other organisations and professionals appropriately involved in the case particularly in responding to the impact of parental views?

6.34 The quality of management oversight in Children's Services was ineffective until October 2015 when a new social worker and manager were appointed, the case should not initially have been allocated to a social worker who had only been qualified for a year and had no experience of working with children affected by CSE, she received little management advice, direction or supervision that enabled her to reflect and adapt her practice; and she carried a large caseload, as a consequence, she was not able to visit Child GG for inappropriately long periods.

6.35 The records evidence a lack of formal and informal supervision for the first social worker and the family support worker and there were gaps in recording when supervision took place and what was discussed. The service was under considerable pressure during the period covered by the review and management posts were covered by temporary locum staff or supported managers in other teams, the restructuring of the Child in Need team and pressure on RAIS increased the level of demand and led to a focus on progressing work through the team rather than ensuring effective practice.

6.36 The co-working of the case between the social worker and the family support worker lacked clarity as to their respective roles and there is no record of joint supervision taking place.

6.37 There was a lack of management 'grip' and recognition of the drift and delay in the case management and planning processes, difficulties in providing co-ordinated services both statutory and specialist were not resolved sufficiently quickly and led to frustration and increased work for the social worker.

6.38 When new Children's Services' management arrangements were put in place for this case in October 2015 there was a marked improvement in the effectiveness of decision making, practice and planning with good examples of senior managers over-ruling previous decisions and clearly recording their views and the reasons for them. The chronology also states that new arrangements have been put in place to ensure that strategy meetings are now better managed, recorded and the actions are implemented.

6.39 The police records indicate an example of effective management oversight when in April 2015, it was identified that an agreed action at a strategy meeting held some months earlier had not been completed, however it still took until mid-June to do so.

6.40 In education, additional safeguarding support has been increased for professional colleagues who seek advice, it is not clear whether this extends to regular case management supervision.

6.41 The chronology makes no reference to the issue of management oversight or supervision in other agencies as required by the terms of reference so I cannot comment on their effectiveness.

Knowledge and understanding of CSE across agencies

Consider whether all agencies when exercising its statutory and non-statutory responsibility could have done more to protect young people from child sexual exploitation and whether the range of options available was in any way limited by the actions of other agencies.

What was the understanding of agencies' roles and responsibilities in relation to perpetrators of CSE?

6.42 The police recognise that insufficient pro-active action was taken in relation to perpetrators and they have positively addressed this in several ways, see above.

How did agencies respond to the growing awareness of CSE?

6.43 Agencies have introduced stronger CSE arrangements, including the introduction of CSE champions in Children's Services, more effective ways of monitoring CSE risk, the use of a CSE risk assessment tool, training, MAECC and triage arrangements.

6.44 Following a recent peer review and subsequent audit, the local authority recognises there is a need for stronger oversight, by MAECC, of children at risk of, or subject to CSE and work on this is being taken forward.

7. PRACTITIONERS/MANAGERS' EVENT

7.1 In July 2016 two events were held to hear from practitioners and managers, their views of the quality of care and support given to Child GG, whether practice had been poor or good why this was; and what improvements had been implemented and what remained to be done. These events were attended by 19 professionals from across agencies. Their views are included throughout this report.

8. RESEARCH

8.1 Research in recent years has identified several challenges; and learning points for all agencies in relation to CSE.

8.1.1 In Ofsted's Thematic Review of SCR's (2011) involving teenagers who were being sexually exploited, they note 'there was a failure to understand the impact of coercion by the abusers on their (young people) behaviours and to assess their capacity to make informed choices' and it also identified criminalization of their behaviour rather than the identification of their victim status. In many of the reviews, the problems of drift, lack of collaboration and coordination, assuming others were managing welfare, and lack of inter-agency challenge were present.

8.1.2 S Hullitt (2016) notes the complex issues involved with caring for young people who are victims of CSE, in that the young person often does not differentiate adults and may perceive the care as negative surveillance. Young people who have fragmented experiences, because of fragility in their families, bereavement and their own cognitive functioning, may have a relationship to power and authority, and adults around them that lead them towards exploitative relationships. She goes on to suggest that CSE is a complex issue, beyond the narrow practice of child protection responses.

8.1.3 The NSPCC Review (2013) notes that CSE can be particularly hard for professionals to recognise and respond to. Confusion around young people's rights and their capacity to consent to sexual activity, means both young people and professionals often wrongly view exploitative relationships as consensual. This means that sexual exploitation often goes unidentified and young people can be reluctant to engage with services. Practitioners need to persevere to engage young people and need to be aware of the child protection implications of sexual activity. The focus should be on ensuring young people's safety, protection, and

wellbeing rather than managing their challenging or risk taking behaviours. This review also notes the need to recognise the child's vulnerability and not criminalize their behaviour and in addition the importance of early and comprehensive assessment. Assessing the capacity to consent must include the consideration of the coercive nature of grooming. The review also notes the vulnerabilities of children involved in CSE. So, whilst there was the opportunity to learn from the Thematic Ofsted (2011) review and information coming out of the reviews in Derby and Rochdale many services were only getting to grips with the impact of grooming and CSE at the end of 2013.

8.1.4 The question for SSCB is whether changes in the meantime would alter the outcome for Child GG if she presented to the system today. Several professionals who participated in this review said they felt the knowledge and management of CSE had improved in the last year and today a child would be more effectively supported.

9. EMERGING THEMES

9.1 During the review some learning themes that were identified included:

- The importance of the skills and time to build effective relationships with children who find it difficult to engage; recognition that some children involved in CSE find it difficult to accept they are being exploited and that some respond well to consistent, clear and structured relationships. It is interesting that Child GG said the reason she got on with some professionals was that they always 'turned up' took 'no nonsense' and she knew they would never 'give up' on her. She said that others did not visit her due to absences from work that were not addressed by management action, that they spoke 'down' to her and treated her like 'a little kid' and she resented both their caring but patronising tone and the fact they said they knew how she felt and what she had been through, when in her view, they could not.

- The importance of professionals understanding the impact of conditions such as ADHD, oppositional behaviour and ASD and the typical features of these in terms of the child's behaviour and understanding. These features can include impulsivity, difficulties in understanding the impact of their behaviour on others and the consequences of their actions. Child GG naturally wanted to be seen as a normal child and was at pains to point out to me that she was 'not stupid or sick'. I was told by some professionals that they knew that, following her diagnosis, she looked up the side effects of her medication and this was the reason she did not want to take it. There were at times difficulties in professionals deciding what was normal adolescent behaviour and what was due to her conditions but there was less understanding of the impact of CSE on her behaviour.

- The importance of skilled, informed supervision and management oversight and the benefits of securing professional expertise such as CAMHS in supporting the understanding of professionals and how best to manage challenging behaviour.

- The need to consider and minimise the impact of a challenging child, especially one who was suffering from the control, fear and influence of external perpetrators, on the family, including the impact on her younger brother and her

mother who was herself the victim of domestic abuse, however unintentional. Child GG's mother describes this summer as the worst they had ever experienced, unable to leave Child GG unattended at any time she has been unable to ensure her son also enjoyed his school summer holidays. Child GG's mother undoubtedly did all she could to control and support her daughter when professionals were struggling to do so too. Arresting her for neglect was a particularly inappropriate thing to do.

- The need to avoid 'blaming' or holding children suffering from CSE as somehow responsible for the abuse; it was very saddening to hear from Child GG that she knew she had done 'bad things' and it was all her fault.

- As identified consistently in SCRs nationally, the importance of professionals sharing information, pro-actively seeking information and clarification and not assuming that they will be told if there is something they need to know. Equally important in terms of sharing information is the need to invite the right people to meetings, during the review some professionals commented that; GPs are not informed if a child is being considered at MAECC nor when a child is missing or excluded from school, until recently health and schools were not asked for information by MAECC and now they are only asked about high risk cases, some agencies said they were not aware of all the activity around Child GG because information was not always shared in referrals to their services, some said they had experienced difficulties in knowing which professionals were already involved.

10. CONCLUSION

10.1 This review examines practice, processes and services during 2015, at the beginning of which, knowledge of CSE in all services was at a low base and agencies did not have effective arrangements in place to identify and address it. There was poor practice, management oversight, supervision and decision making in Children's Services; although practitioners were committed to Child GG they were not able with others to prevent the abuse due to a lack of knowledge, skills, capacity and a co-ordinated approach within which to work, however, the improved management oversight in October 2015 marked a turning point in the case with significant improvements evident across services.

10.2 The police recognise that their knowledge of CSE, absence of designated specialist officers and a lack of focus on perpetrators and the measures the police could take to divert and gather information on them, were key factors until late in 2015, the introduction of MAECC was a positive development but it took time to work effectively and a recent review has identified further improvements to be made.

10.3 Although Child GG received significant support and commitment from one school she did not have a statement of Special Educational Needs. Her mother feels this is the thing that could have helped most; that had her daughter had additional support she would have been able to remain involved in school, had fewer behavioural difficulties and exclusions and ultimately being sent to what were in her view 'unsuitable schools'. The SEN was first suggested when Child GG was in year 7 but her mother feels there was resistance to the forms being completed as it was believed there was nothing wrong with her daughter and the problem was the relationship between them. It was not until earlier this year (2016) that the SEN plan was completed, well outside expected timescales. Child GG received very little education during 2015, despite the

statutory amount to be provided is 25 hours per week, this could have had a detrimental impact on her education and her future outcomes unless they are being addressed.

10.4 The level of confusion about what specialist and support services could deliver and what their criteria were, led to wasted time and effort and from comments made at the practitioner's event appears to remain. There appeared to be a lack of flexibility about services to meet the needs of the child.

10.5 During 2015, significant parallel improvements were taking place, awareness of CSE was raised considerably, additional services were being put in place, MAECC and triage arrangements became established and management oversight and supervision improved in Children's Services health and education.

10.6 This report sets out the improvements that have been put in place and the commitment, increasing knowledge and confidence of practitioners in identifying and addressing CSE. However, two peer reviews, of CSE including one by the Local Government Association and one of MAECC by an Independent Consultant, have made a substantial number of recommendations. It is for agencies and the SSCB to determine the extent to which improvements have been made and the recommendations from the external reviews have been implemented and are making a real difference and what improvements still need to be developed and delivered.

11. RECOMMENDATIONS

The SSCB should:

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 knowledgeable 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, reflective supervision and management oversight and decision making is implemented across agencies, acknowledging that supervision means different things in 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 just those involved in CSE and where necessary re-commission or commission services to fill the gaps. Whilst this work is being undertaken, knowledge about what services provide, their thresholds and the referral pathways should be widely shared.

Appendix 1

Scope and Terms of Reference for the Serious Case Review (SCR) in relation to Child GG

Elaine Coleridge-Smith Surrey Safeguarding Children Board (SSCB) Independent Chair agreed to hold a Serious Case Review on 30/03/2016.

A Serious Incident Notification to Ofsted was made on 19/05/2016.

1. The events leading to the decision to conduct a SCR and scope of the review

The SSCB is undertaking a SCR as a result of a referral by Surrey Police. A request for information was sent to all partner agencies that are members to the SCRG for information and upon consideration of the submitted information it was agreed that the criteria were met for a SCR.

The SSCB will review the management of involvement by all agencies with Child GG and her family in line with the requirements in chapter four of Working Together 2015. The review seeks to explore how agencies worked together in identifying and managing risks, especially around child sexual exploitation. The review will identify strengths and improvements in the safeguarding system, especially in relation to child sexual exploitation, as well as potential learning for the LSCB and partner agencies

2. Methodology of the SCR

This Serious Case Review is going to be carried out using some of the principles embedded within the SCIE approach. This methodological approach has been selected to enhance the understanding as to why decisions were made and services delivered in a particular way and to assist the benchmarking of the impact of recent changes to the multi-agency approach to CSE. It is really important that agencies and individuals involved in providing services to Child GG and her family recognise that the purpose of this process is to identify learning and not to apportion blame.

Agencies will be asked to provide a chronology detailing their involvement with Child GG and any relevant data with other family members, namely her mother and sibling (Child H). As part of the chronology, agencies are requested to include comments against entries where appropriate to enhance the understanding of the context of their involvement. Practitioners that have been involved in providing services to the family will be invited to attend a facilitated event, where the key terms of reference will be explored. Following this event, individuals and managers, where relevant, may be contacted by the overview author to provide further clarification. The independent author will compile a report based on information from chronologies, the practitioners' event and individual consultations with practitioners and managers. This report will be shared in a follow-up event with practitioners who participated in the earlier facilitated event and managers who might have been consulted.

At the start of the process, a briefing event will be held for the professionals that will be involved in writing the chronology or attending the facilitated events and individual consultations. Managers are also welcome to the briefing event as they may be consulted on a one-to-one basis.

3. Terms of reference of the SCR

The purposes of this review are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

The experiences of Child GG and how well services responded to her needs will be explored through the facilitated event and individual follow-up consultations (if required), by considering the following broad themes:

1. Risk assessment and decision making
    - What were the key points for assessment, decision making and effective intervention in this case and what was the quality and timeliness of decision-making?
    - Were the risks of sexual abuse and/or sexual exploitation to Child GG while missing from home and school effectively considered and responded to appropriately?
    - What was the quality of multi-agency risk assessments and were Child GG's mental health needs assessed and treated appropriately?
    - Was the level of vulnerability and risk to Child GG fully understood by the different services within an organisation and effectively communicated between different services and partner agencies?
    - Is there any evidence that a focus on other risks impacted negatively on the identification of possible child sexual exploitation?
2. Intervention and aligned processes
    - How effective was the Missing and Exploited Children (MAECC) procedure and its implementation in this case? What was known about child sexual exploitation at the time?
    - Were there any issues in communication, information sharing or service delivery, within, between or across localities and services, including services commissioned jointly by the agencies? Agencies should make

particular reference to the arrangement for escalation of concerns within and between agencies to more senior officers.

- When different services within agencies became involved with Child GG, was her family history sufficiently explored and understood to enable these services to fully understand the vulnerabilities and risks?

- When Child GG and her mother failed to engage fully with services provided, were services sufficiently persistent in promoting engagement or were there missed opportunities? Did the services within agencies have effective procedures to deal with non-engagement or non-attendance and were these procedures folllowed?

- Did the services effectively communicate with Child GG in a way that she could fully understand? Were there any missed opportunities to communicate more effectively, particularly in respect of her Special Educational Needs?

3. Management oversight/supervision and accountability

    - Was there sufficient management accountability for decision-making? What was the quality of supervision? Were senior managers or other organisations and professionals appropriately involved in the case particularly in responding to the impact of parental views?

4. Knowledge and understanding of CSE across agencies

    - Consider whether all agencies when exercising its statutory and non-statutory responsibility could have done more to protect young people from child sexual exploitation and whether the range of options available was in any way limited by the actions of other agencies.

    - What was the understanding of agencies' roles and responsibilities in relation to perpetrators of CSE?

    - How did agencies respond to the growing awareness of CSE?

4. Time period for review

The principal focus of the serious case review will be from 01.01.2015 until 31.12.2015.

The review will invite all agencies to provide a summary of all significant events and relevant family history outside the specific scope and timescale, where this will help to inform the overall analysis.

5. SCR panel membership

The SCR group will be formed from the following agencies: Surrey Children's Service, Surrey Youth Service, Surrey Schools and Learning, Surrey Police, Local Clinical Commissioning Group, National Probation Service and Kent Surrey Sussex Community Rehabilitation Company.

The SCR group is chaired by Amanda Boodhoo, Designated Nurse for Safeguarding.

The SCR overview author will be Glenys Johnston Independent Safeguarding Consultant.

Additional members will be co-opted if specialist knowledge is required.

6. Surrey agencies currently believed to be involved

The following agencies are known to have been involved at this point:

- SCC Children's Services
- SCC Youth Support Service
- SCC Schools and Learning
- Surrey Police
- CAMHS
- Local health provider of community services
- Local hospital
- Mental health preventative day service
- Young people's substance misuse service
- Local Clinical Commissioning Group (Surrey General Practitioners)

If other agencies are identified they will be asked to contribute as appropriate.

7. External agencies currently believed to be involved

No agency external to Surrey identified as being involved in this case.

8. Managing public, family and media interest

Family interest in the review will be considered by the SCR and the panel chair. Child GG and members of her family will be invited to contribute to the review by meeting with the overview author towards the end of the process.

Media and other public interest in the review will be managed in line with the agreed SSCB press / media strategy. The subjects and other family members will not be identified by the SSCB and all agencies will take whatever steps are appropriate to reduce the likelihood of identification in criminal proceedings if these occur.

9. Legal advice to the SCR

The Principal Solicitor Surrey County Council is an adviser to the SSCB and will advise the SCR panel, SCR panel chair and chair of LSCB as required.