Gloucestershire Safeguarding Children Partnership

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire
COUNTY COUNCIL

Local Child Safeguarding Practice Review

Thematic Review of Child Exploitation Safeguarding Practice

February 2021

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Contents

1. Introduction

During June and July 2020, the Gloucestershire Safeguarding Children Partnership (GSCP) scrutinised three separate cases where a young person had suffered significant harm and which had involved Child Sexual Exploitation (CSE). They recognised the potential to improve the way agencies worked together to safeguard young people and commissioned this Local Child Safeguarding Practice Review (LCSPR)[1].

An independent author was appointed to work with the safeguarding partners in a thematic review of safeguarding practice and structures. The intention being to use the experiences of the three young people to guide a wider review, focusing on strategic development rather than an individual case. Its purpose to:

- Support the development of safeguarding practice and services.
- Identify potential improvements to safeguard and promote the welfare of children and young people.

A wide number of agencies participated and key thematic areas offering the potential to improve outcomes for young people were identified. These are dealt with in this report as follows:

a) Multi- agency recommendations, which are considered in the section headed 'Exploitation Strategy and Commissioning of Services'.

b) Single Agency Recommendations, which are outlined in the section headed 'Referrals and Assessment of Need'.

2. Methodology

An independent lead reviewer was appointed to work alongside a panel of local professionals who met to undertake the review. Chronologies and single organisation reviews were provided by each agency, analysing practice events and considering how changes to practice may deliver future improvement.

The independent reviewer met with the young people to ensure that their views were fully considered, particularly how processes and procedures impacted upon them.

Practitioners and senior representatives from each agency met for the further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for further consideration by the Safeguarding Executive.

This report outlines the strategic recommendations in a concise format for consideration by the safeguarding executive. It is written with the intention of publication and as such does not contain information which may identify the young people involved. The detailed analysis of cases and the

[1] Chapter 4 of 'Working Together 2018 ' details the purpose of safeguarding reviews. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

evidence underpinning this report are held in additional documents retained by the Safeguarding Executive.

3. The Young People

3.1. An Overview

The experiences of the young people have been essential in guiding the review and the analysis of practice. Each person was considered individually, allowing the review to identify common safeguarding themes experienced in their childhood and in their adolescent years. This short overview provides context to the report.

Each person experienced significant Adverse Childhood Experiences (ACE)[2]. Common themes from their home environment included: Domestic abuse in the home, child neglect; parental mental and emotional health issues; parental use of alcohol and drugs. The most significant factor in their experiences being the lack of a positive and supportive adult relationship in their life. This was despite partnership agency involvement to support them and their families.

During their adolescent years each went on to be exploited by older males. This resulted in significant emotional harm, in addition to serious physical and sexual assaults. There was a pattern of alcohol and drug use, a large number of missing person episodes, and self-inflicted injuries.

3.2 Experience and Views

There were common themes in the views provided by the young people. The key issues presented as follows:

- Effective support was not provided in their early childhood which may have helped to prevent them from suffering harm. Neglect and domestic abuse in the home made them more vulnerable to future exploitation.
- They felt let down by the 'system' and felt that some professionals were not interested in them as individuals. The services provided were inconsistent and did not provide them positive outcomes.
- When provided accommodation by the local authority they felt it unsuitable. It was often subject of change at short notice which was very unsettling. One of the young people had at least twenty different placements, making it impossible for her to have a stable education or to form close friendships.
- They did not feel listened to. Often the only way to be heard was to act in a way that was subsequently termed disruptive by adults who were supporting them.
- It was clear that not having stable positive adult relationships in their life (parental or others) provided perpetrators the opportunity to exploit them. They describe feeling alone.
- There was a mistrust and dislike of the Police, who were often the ones who would 'force' them to go home after having been reported missing.

[2] Described on the 'Gloucestershire Action on ACES' website - https://www.actionaces.org/

- All now wanted the opportunity to have further education, employment, and to form positive stable relationships. They described wanting to take responsibility for improving their emotional health, but wished to have support in helping them achieve this. The provision of mental and emotional health support was a key issue.
- Whilst each looked forward to greater independence at the age of eighteen, they identified the need for continued support from agencies into early adulthood.

4. Exploitation Strategy and Commissioning of Services.

4.1 Overview

Throughout the review it was identified that whilst current services were well structured to work with younger children, there was a lack of understanding in identifying the needs of adolescents and a lack of pathways to provide effective safeguarding. This is a national issue previously identified by the Association of Directors of Children's Services, who in 2014 commissioned the Research in Practice group to explore the issue. Their subsequent publication 'That Difficult Age'[3] evidences how a contextual safeguarding model[4] could improve the capability to safeguard adolescents and produced seven key principles to improve responses to adolescent risk.

The current GSCP Child Exploitation Strategy is not based upon a contextual safeguarding model. It aims to provide safeguarding through four defined action plans[5], however it does not address the strategic issues needed to underpin this activity or the commissioning of necessary services.

If improvements to safeguarding adolescents are to be delivered a new multi-agency exploitation strategy will be needed in Gloucestershire. The current strategy covers the period April 2018 to April 2021 and it is therefore a good time to commence development of its replacement. The basis of any future strategy should be to develop a partnership vision as to how adolescents will be protected through a contextual safeguarding model. This should include all types of exploitation, including:

- Child sexual exploitation.
- Child criminal exploitation.
- Missing children.
- Harmful sexual behaviour.
- Peer on peer abuse.
- Human trafficking.

To develop a new strategy and for the continuous improvement of safeguarding practices, a clear governance structure is required. It is recommended that the GSCP refresh the current Child Exploitation sub-group with a clear term of reference and accountability for maintaining an overview of exploitation in the county.

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[3] https://www.researchinpractice.org.uk/children/publications/2014/november/that-difficult-age-developing-a-more-effective-response-to-risks-in-adolescence-evidence-scope-2014/

[4] This is an approach to understanding and responding to young people's experiences of significant harm beyond their families, in a range of different social contexts and differing communities.

[5] Prepare, Prevent, Protect, and Pursue.

The remainder of this report section provides guidance as to what should be considered in any new strategy. It includes the following key issues identified during the review:

4.2 Contextual safeguarding.
4.3 Commissioning services.
4.4 Perpetrator disruption strategy.
4.5 Multi-agency planning pathways.
4.6 Missing children and MACE.
4.7 CSE team.

4.2 Contextual Safeguarding

The research completed by the Research in Practice group would be a useful place to start in developing the partnership vision in Gloucestershire. Further reading to inform the development of strategy would be the University of Bedfordshire[6] Contextual Safeguarding programme. This provides guidance on a legal framework and provides access to a number of studies as to how contextual safeguarding has been implemented elsewhere.

4.3 Commissioning Services

Once a set of key principles has been set, the partnership may then identify the pathways of support required and ensure that services are properly commissioned, including the necessary funding and resources. This should include consideration of the following:

- Social, Emotional and Mental Health Services.
  The lack of effective pathways to support the emotional health needs of young people was critical during the cases examined in the review. Children's and Adolescent Mental Health Services (CAMHS) are currently commissioned to support those people with a diagnosable mental health illness, which is not the case for many young people with emotional health needs. Currently young people are not receiving the support they need.
- Enhanced Early Help Offer
  The absence of supportive adult relationships made it extremely difficult for the young people to work with services, which was evidenced across many different settings. This was exacerbated when a number of services became involved and the need for greater coordination was shown. In a refreshed early help offer there is a need for a new role to support the young person and coordinate services.
- Transition into Adulthood.
  Support for young people with complex needs should continue once they reach the age of eighteen and into their early adulthood. Continuing services to the age of twenty five would be proportionate, which will require the commissioning of appropriate services.
- Accommodation
  The provision of unsuitable accommodation was also a significant factor in the lives of the young

[6] https://www.beds.ac.uk/ic/current-projects/contextual-safeguarding-programme

people. Stable and consistent placements need to be provided if the confidence of young people is to be gained and to reduce the frequency of missing episodes.

4.4 Perpetrator Disruption Strategy

This review highlighted the need to improve the way perpetrators are managed in Gloucestershire and this should form an essential part of any new exploitation strategy. An effective disruption strategy should achieve three key priorities:

a) The early identification of exploitation in communities through the review and analysis of partnership intelligence. Effective systems should be developed to provide problem profiles and also to respond to new partnership intelligence.

b) Multi-agency work with perpetrators to change behaviour, particularly where the person posing the risk also has vulnerabilities and specific needs. This will involve the commissioning of necessary adult services.

c) Robust enforcement of offences committed by known perpetrators. This includes a 'gold standard' of criminal investigation for identified offences and the enforcement of bail conditions. This should also include proactive investigation strategies to disrupt offenders when substantive offences cannot be prosecuted due to evidential difficulties[7].

The MAPPA[8] model provides a good governance structure for this type of activity. Consideration should be given to replicating this model, or using the established MACE[9] meeting for this purpose. The chair of this forum should be experienced in the management of high risk offenders.

4.5 Multi-Agency Planning Pathways

A clear structure for multi-agency planning meetings should be developed for adolescents with complex needs. The structure should be streamlined with as few forums as possible and have clear purpose and accountability. The exploitation strategy should highlight that all agencies have responsibility for planning and that this should not be left to one single agency.

It is recommended that the frequency of planning meetings is limited to ensure a consistent attendance of professionals who are actively involved in the case. Effective contingency planning should prevent the need for short notice meetings to respond to the fast pace of young people's lives. This is preferable to holding 'strategy discussion' meetings following a specific incident. Such short notice meetings hinder consistent attendance, reducing the effectiveness of information sharing and effective planning. They also increase the likelihood of developing a 'crisis led' approach to planning, rather than focusing on longer term needs.

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[7] The College of Policing provides guidance for disruption strategies.

[8] Multi-Agency Public Protection Arrangements. https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/mappa/

[9] Missing and Child Exploitation Panel

4.6 Missing Children and MACE

The risk of exploitation increases when young people are frequently missing or absent from their home or care placement. This was particularly evident in this review, where the young people were often absent and in the company of adult males who were suspected to be perpetrators. As their location was known they did not meet the technical definition of 'missing', but were nonetheless in need of protection from potential abusers.

Multi-agency protocols should recognise this risk and provide clear guidance as to how agencies will work together to protect young people. The Gloucestershire protocol at this time did not achieve this, the term absent from home is not used in the protocol, requiring all children to be responded to as 'missing'. It is clear though there was confusion in how missing protocols[10] were applied and this led to an inconsistent response to missing reports. That inconsistency increased the risk to the young people and in one case led to a young person being raped by a known perpetrator.

New missing protocols should be developed in Gloucestershire and should consider the following.

- A contextual approach to reducing missing person episodes. Recognising that as young people become older, they will want a greater level of independence and will not necessarily see themselves as missing.
- Clear categories of 'missing' and 'being away from a placement without authorisation', particularly where the risk of exploitation is known. This should provide clear guidance as to how episodes are reported, recorded and managed.
- Processes to identify increasing risk to individuals, patterns of exploitation, and emerging sources of exploitation. This should include how information from return home interviews is used and how strategic exploitation profiles are regularly commissioned to drive activity. The Child Friendly Leeds partnership has a useful short guide to their processes[11], which includes the daily multi-agency review of all missing episodes and a two monthly strategic review.
- Revisit the role and purpose of the MACE. Both in terms of maintaining a strategic overview of exploitation and how it supports individual cases. Consideration should be given to how it fits into exploitation governance structures within the GSCP, in addition to clarifying any accountability it may or may not have for individual cases. Pathways should be developed encouraging professionals working at a local level to raise cases for consideration.

4.7 CSE Team

The multi-agency CSE team is an exceptional resource which includes professionals from a diverse range of agencies. Whilst this is an example of good practice in relation to sexual exploitation, similar structures do not exist for criminal exploitation and other forms of exploitation. As part of a new exploitation strategy the role of this team should be repurposed to address all types of exploitation. A review should include the resourcing of the team and the commissioning of necessary agencies and services.

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[10] Extract from page 21 – "Unauthorised absence is not a category of absence which should be reported to the Police. The responsibility for managing this category of absence lies with the manager of a residential care home or carer."

[11] https://www.leeds.gov.uk/docs/MACE%20Framework.pd

A review of the CSE team will provide an opportunity to develop its links to professionals working in the community, particularly how it integrates with locality social care teams and how its expertise and resources are accessed.

Recommendation 1:	*The GSCP should develop a new Child Exploitation Strategy, based upon the principles of contextual safeguarding. This should include the identification of relevant pathways and the commissioning of services.*

5. Referral and Assessment of Need.

5.1 Trauma Informed Assessment

During the review there was clear evidence that in a variety of settings child protection concerns were identified quickly and referred to appropriate agencies. One of the key learning points is how these referrals were then assessed and the efficacy of subsequent planning. It was apparent that agencies tended to respond to the facts of a particular referral in isolation, focusing on addressing the behaviour described in that moment in time. This was at the expense of building an enriched picture to understand what was happening in children's lives and the underlying reasons for the referral. As a result planning focused on delivering short term outcomes rather than addressing longer terms needs.

Each young person had suffered trauma in their childhood and had significant Adverse Childhood Experiences, a significant risk of exploitation being the absence of supportive adult relationships. In not fully understanding how past events had affected the young people, their needs were not understood and this compromised the effectiveness of initial planning. As a result future safeguarding issues continued and the risks escalated to the stage where they became at high risk of exploitation. At this time the young people lost confidence and trust in professionals, which made further support extremely difficult.

To support a new exploitation strategy each agency should make changes to their assessment process, ensuring that it is ACEs led and focused on supporting young persons needs. This is a key action and essential to improve outcomes for young people.

Recommendation 2:	*All agencies should introduce a trauma informed referral assessment process which is child and young person focused.*

5.2 CAMHS Referral Process

The CAMHS referral process is an area which needs review and change to ensure that it is child focused. Referrals have been rejected due to the quality of the referral, rather than on the child or young persons needs. This has led to repeated referrals and has significantly affected the levels of confidence that safeguarding professionals have in the process. It has also led to delays in delivering services to those in need.

The review also identified a reliance on parents to be engaged in the services offered by CAMHS. This is an issue which needs to be changed, especially when dealing with young people who are the subject of child neglect.

Recommendation 3:	*CAMHS should review the current referral process to ensure that it is child and young person focussed, and that the new referral process is widely understood & promoted across partner agencies.*

5.3 Gloucestershire Constabulary Information Sharing

Gloucestershire Constabulary has an established process for the identification and referral of safeguarding issues by front line staff. This involves the use of an electronic form (Vulnerability Identification and Screening Tool – VIST) and all operational staff have had recent awareness training. The review found that safeguarding concerns were regularly not identified and shared through this process. In the most serious cases the police became aware of sexual assaults on young people and did not share this information. Opportunities to record and share safeguarding concerns during missing person enquiries were also missed. The review did not have the information to identify the cause of these omissions. It is not known if this is widespread for all child protection matters, or only in relation to adolescents.

Recommendation 4:	*Gloucestershire Constabulary should review compliance with their VIST safeguarding policy in relation to adolescents and ensure measures are in place to improve the identification and reporting of adolescent risk.*

6. Conclusion and Response to Recommendations

5.1. Concluding Comments

The Gloucestershire Safeguarding Children Executive should now consider the recommendations from this review and how they intend to deliver improvements to safeguarding practice. In addition to addressing multi-agency recommendations it should hold individual agencies to account for delivering the single agency recommendations.

5.2 Gloucestershire Safeguarding Partnership Response to the Recommendations

Recommendation 1:
The GSCP should develop a new Child Exploitation Strategy, based upon the principles of contextual safeguarding. This should include the identification of relevant pathways and the commissioning of services.

Response:
The partnership has committed to taking the lessons from this LCSPR and to rewrite its strategy working with the National Working Group (NWG) to advise and support the creation of a Young person's 'Outside the Home' Strategy". As per Jack Cordery's paper this needs to include the following:

A strategic and systemic approach

- A clear multi-agency Mission Statement and Strategy, with an outcomes framework – also spelling out that children and young people are never seen as responsible for becoming victims of exploitation (e.g. Rotherham and others)

- The strategy covers children and young adults up to 25 years of age
- Incorporated into the Organised Local Crime Profile
- Governance through the statutory Safer Community Partnership – in conjunction with both Safeguarding Children Partnership and Safeguarding Adults Boards (possible joint sub-group)
- Closely linked to and cross cutting Sexual Abuse Strategy – including online risks
- Closely connected to Children and Young People Missing Strategy (home, care and school)
- Closely connected to strategy aimed at reducing part-time school timetables, exclusions and long-term alternative provision – expectation of a Criminal Exploitation risk assessment
- A Criminal Exploitation (and Missing) Operational Lead, at a senior level (e.g. a member of the Senior Leadership Team) and a specialist practitioner within the Multi Agency Safeguarding Hub
- Raising the awareness and skills of all disciplines to recognise the signs of exploitation
- Training in work with adolescents targeted to those most likely to be seen as trusted adults
- Regular campaigns to raise awareness among children and young people, their parents/carers and community groups
- Campaigns aimed at hotels/B&Bs, taxi drivers and fast food outlets – link to licensing
- Monthly multi-disciplinary area Criminal Exploitation Panel to discuss children, persons, vehicles and places of concern
- Specialist joint-funded multi-disciplinary Disruption Team, including a specialist legal officer working closely with the Police 'vulnerability lawyer' to promote and co-ordinate criminal, civil and partnership options to disrupt Criminal Exploitation in line with NWG/Barnardos Disruption Toolkit

Building staff confidence and capabilities

- Ensure practitioners across the system, especially those who work with adolescents, have a clearer, research informed understanding of the risk factors and vulnerabilities associated with exploitation, and a more holistic understanding of the dynamics of grooming and exchange which underpin exploiting relationships
- Include commissioned services; activity, education and care providers
- Staff have confidence and knowledge about how to take effective action – the options available and how to implement them
- Investment in specialist training such as the innovative 'Stopping me seeing the people I love' training – developing specialist adolescent relationship-based practice
- Investment in training by a specialist lawyer in legal intervention options, to support the introduction of the Joint Disruption Legal Planning Meeting protocol
- A regular 'bulletin' by the Operational Lead shared with staff and partners to highlight themes and areas of emerging activity county wide, especially successes in disruption

Recommendation 2:

All agencies should introduce a trauma informed referral assessment process which is child and young person focused.

Response:

In direct response to this recommendation, referral and assessment processes will be reviewed to ensure they are trauma informed and the child's voice is clearly represented. This has already commenced with the new child exploitation screening tool. Reviews will now be undertaken of the MARF and VIST. These reviews will take place with the support of partners such as the Nelson's Trust who are accredited trainers for a trauma informed approach. To further ensure a trauma informed approach is taken when completing and assessing referrals, training will be sought for staff and woven into existing processes. An example of this is demonstrated in the TIMOC pilot being conducted with Trevone House staff group

Trauma Informed Model of Care (TIMOC) – Childrens Social Care are commissioning Dr Ana Draper from the Tavi and she is pursuing training with the Trevone House staff group and the Social Workers and Team Managers for the young people moving in to Trevone House. This is currently a pilot with a boarder plan to roll out across the Childrens Social Care workforce and with identified partners. Match funding has recently obtained from the DfE to support the improvement and transformation programmes which may support this. Contributions from the GSCP and its relevant agencies would be required to roll out across the safeguarding partnership.

Recommendation 3:

CAMHS should review the current referral process to ensure that it is child and young person focussed, and that the new referral process is widely understood & promoted across partner agencies.

Response:

We welcome the recommendations for mental health services in this review.

Emotional health and wellbeing in its broader sense for children and young people is supported from prevention and promotion of good mental health through to support and interventions on a spectrum of need. This includes through parents and carers in the home setting, through schools, children's services, in communities and through statutory and voluntary sector providers. There is a range of support on offer depending on young people's needs and through a variety of means. CAMHS is a specialist mental health service that works as a part of this system of support.

Gloucestershire is one of 12 national NHS England pilot sites to look at transforming CAMHS and wider mental health services in our County.

As part of the pilot mental health transformation programme we have worked with

- Public health to complete a review of need.
- Children, families, clinicians and stakeholders locally to gain insight into what works well, and what needs to improve. We continue to co-design our new offer going forward.

- NHS England Improvement in a system wide review of mental health support for children and young people in Gloucestershire.

This has resulted in a number of recommendations to take forward in our transformation journey which include:

- Better quality of referral information which will enable the principle "no referral is rejected" but forwarded to most appropriate option for support, by developing robust referral criteria/referral form and communicating this to all stakeholders.
- Telephone triage with all families as a first contact to ensure that all of the information is captured at referral point and options can be discussed directly with children and young people and their families, creating a better journey for families.
- When referrals are received and other children's services are involved there will be a multiagency meeting arranged to ensure that we are working together with partners to best support children and family's needs in the round.
- Create a central resource where we describe our system wide offer of support to children, young people and families and provide information about support available, clearly articulating the offer. This includes implementing the principles of THRIVE. http://implementingthrive.org/wp-content/uploads/2019/03/THRIVE-Framework-for-system-change-2019.pdf
- Longer term we aim to work with system partners to develop a single point of access by operationalising a system-wide 'front door' calling upon the expertise and skills from across the system adopting the philosophy that no request for support is rejected.

In addition we are evaluating our pilot of providing therapeutic input to foster carers and social workers to best support children in care.

We are committed to incorporate the recommendations into our referral management transformation and articulation of the offer working with children, families and stakeholders.

Recommendation 4: Gloucestershire Constabulary should review compliance with their VIST safeguarding policy in relation to adolescents and ensure measures are in place to improve the identification and reporting of adolescent risk.

Response:

Significant work has been undertaken to review and refresh the Constabulary's VIST guidance. The VIST itself will now be reviewed to ensure it accurately reflects appropriate and proportionate aspects of the Neglect Toolkit and a trauma informed approach. This work will continue in the first quarter of 2021 with future plans for education and awareness raising of some of the complexities identified through this LSCPR.

An audit has been conducted into the quality of VIST submissions which has identified common themes and misconceptions; this information is being used to ensure training is focused on the core issues.

Training, started in August 2020, will continue targeted at a range of front line staff and then across other areas of the organisation.

Changes to the MASH and Public Protection intranet pages are planned to ensure information is constantly available for reference.

Regular check and test processes are in place at various levels to correct compliance issues and ongoing compliance and quality assurance will be tested with monthly quantitative and qualitative evaluation. The outcome of this piece of work in response to this recommendation will be reported to the CE and Missing Subgroup in April 2021.

While this recommendation specifies the Constabulary it has been recognised that all partners should review their compliance and quality in respect of the identification and reporting of risk. Indeed similar reviews in the auditing of MARF submissions has already started in GCH along with work in CSC to add the new CE screening tool to their online workspace to highlight identification of risk. This wider partnership work will be monitored by the CE and Missing subgroup and the GSCP management group.