Calderdale Safeguarding Children Board Response to the Serious Case Review into Child M (Jeanette)

Introduction:

This document sets out the formal response of the Calderdale Safeguarding Children Board (CSCB) to the findings and learning identified through the Serious Case Review (SCR) it commissioned following the serious harm that came to Child M, known as 'Jeanette'.

It provides key information about the SCR process and its purpose and also gives an overview of how it was conducted and who was involved. Importantly it sets out the learning for the CSCB as the partnership responsible for ensuring that joint working arrangements to protect children are effective. It also shows how the CSCB partnership will support and monitor the implementation of learning by each of the involved agencies.

All partners who are members of the CSCB have formally accepted the report and endorsed the findings. This response should be read in conjunction with the full Overview Report. These documents seek to demonstrate and support the transparent and objective approach all parties have taken to looking at and learning from the abuse of Jeanette.

1.0 SCR Information

Working Together to Safeguard Children 2015 (WTSC, 2015) is clear that SCRs are a part of the learning and improvement framework that all Local Safeguarding Children Boards (LSCBs) must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve. The purpose of a SCR is to conduct "a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children," (WTSC 2015, page 72).

Serious case reviews must seek to:

- Identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
- Be transparent about the way information is collected and analysed; and
- Make use of relevant research and case evidence to inform the findings.

1.1 Background to the serious case review

This SCR is about a remarkable young woman, who was abused by a large number of men over the period 2008 to 2011 (when she was 12 to 15 years old). Jeanette came through a life full of difficulty, upset, neglect and sexual exploitation to arrive at a point in her life where she was able to assist the police in bringing 17 successful prosecutions for a variety of trafficking and sexual offences including rape. Jeanette had been seriously harmed and there were concerns about how organisations and professionals worked together to safeguard her and therefore the case met the criteria to undertake a SCR.

2.0 Methodology

SCRs are commissioned by LSCBs when a child has died through abuse or neglect or been seriously harmed and it is believed lessons can be learned from the way in which the local authority, their board partners or other relevant persons have worked together to protect the child. LSCBs are now able to design the way in which they carry out these reviews.

The CSCB decided that this review would have a panel of senior managers (independent from the case) from local agencies who work with children, written reports from each agency written by managers who were independent of the case and two people independent of both the case and Calderdale agencies; one of whom would chair the panel and one of whom would lead the review and produce the Overview Report.

The review involved consultation with a high number of staff and members of the public including:

- Jeanette
- Practitioners who had worked with Jeanette and their managers
- Discussion with senior managers of children's services in Calderdale, (via the Panel)
- Focus groups with members of Halifax's British Asian community
- Jeanette's current social worker
- The senior police officer leading the enquiry
- Experts in child sexual exploitation and race issues, (from Universities and the Children's Society)
- Jeanette's foster carers

The report was guided by terms of reference completed by the Panel. Those terms contained some questions (listed below) set by the CSCB at the beginning of the review process. These questions were addressed by each agency report author and assisted the author in understanding what had happened and why.

1. Determine whether the National, Regional and Local policies, procedures, thresholds and practice expectations of the agencies in use at the time were followed during this period. How would this be different now?
2. The vast majority of people who were questioned in regard to sexual offences against Jeanette are British Asian men of a Pakistani heritage. What, if any, are the gender, race and culture issues that are relevant to this case?
3. Were single and multi-agency communications and information sharing appropriate, accurate and acted upon?
4. Were single and multi-agency assessments and interventions child focussed, appropriate, accurate, acted upon and complete?
5. Consider whether there are any common themes from previous serious case reviews or critical incident reviews and the effectiveness of agency's actions in relation to these.
6. Identify learning that will help partners and the LSCB to strengthen understanding of and response to Jeanette and to all vulnerable children and young people.
7. Did agencies understand and implement policy and practice in relation to CSE in their contact with Jeanette. If not, why was this??
8. Were any of the professionals or organisations involved with Jeanette working in isolation?

9. What can we learn from the engagement with the young person, parents and extended family in fully understanding vulnerability, harm, risk and effective interventions?
10. Was professional practice informed by appropriate and effective supervision?
11. Were there examples of challenge by the LSCB into systems and processes of identification and monitoring of victims of CSE and were there occasions when challenge might have made a difference?

The following organisations produced reports detailing their involvement with Jeanette, critiquing the practice of the professionals involved whilst considering broader contextual issues relating to guidance, systems and processes.

- Children's social care (Calderdale Metropolitan Borough of Calderdale or CMBC)
- Independent reviewing service (CMBC)
- West Yorkshire Police
- Youth offending service
- General Practitioner's service
- Calderdale and Huddersfield NHS Foundation Trust
- Education
- Surestart (Partner Support Worker in School)
- National Probation Service

3.0 Key Learning

The three main agencies, police, health and children's social care initially failed to protect her, despite attempts made by individual professionals, until she realised she had been abused and actively sought out help. Jeanette decided in December 2011 that she wanted to talk about the abuse that she had suffered and, in contrast to the failures prior to this: work was co-ordinated, people understood their roles and Jeanette accepted that she was abused and responded positively to the guidance that she was offered.

Changes to joint working arrangements for protecting vulnerable children from child sexual exploitation meant that the author found current practice to be much improved and he was 'confident that practices, systems and processes have improved both the services to children in need and children at risk from significant harm and sexual exploitation in Calderdale'.

The review did not find that professional staff in Calderdale were fearful of discussing issues of race and culture nor any evidence that anyone higher up in the organisations placed pressure upon professionals to cover up any discussions that could damage community cohesion. This review has considered the relevance of race and culture and identified issues that related directly to this case and others that are broader and require further research.

The review suggested some themes or findings, which are further developed in the recommendations (section 4.0). They are as follows:

- The role of culture
- The role that substance misuse played
- Ethnic mix of staff in the public sector in Calderdale
- How to help children who don't know they are being exploited and abused
- Escalation and supervision
- Learning from the case

4.0 SCR Recommendations

RECOMMENDATIONS

Some of these findings have been translated into recommendations or learning points which require further consideration. These are:

The role of Culture

1. The review makes a national recommendation that there be further academic research into the cultural identity of perpetrators of localised grooming and suggests that gender power, bridging and bonding, criminality, male attitudes towards women and openness about sex and relationships be areas that research should consider.

2. The review recommends that Calderdale safeguarding children board assures itself that statistics relating to perpetrators are accurate.

3. The review recommends that Calderdale safeguarding children board asks the child sexual exploitation operational group to produce a plan relating to how they will make use of the statistics collected relating to the cultural background of perpetrators.

The role that substance misuse played

4. The review recommends that Calderdale's child sexual exploitation hub collect statistics relating to the known criminality of perpetrators with the intention of further considering the role that illegal drugs plays in the sexual exploitation of children.

5. The review recommends that Calderdale safeguarding children board ensures that professionals working with children and young people are able to identify and act upon drug and/or alcohol use, including making referrals to specialist services where appropriate and that drug and alcohol workers are fully trained in understanding issues of child sexual exploitation.

The ethnic mix of staff in the public sector in Calderdale

6. The review recommends that Calderdale safeguarding children board continues to support the work of community liaison officers and conducts a survey of its members to determine the ethnic mix of staff.

How to help children who don't know they're being exploited and abused

7. The review recommends that Calderdale safeguarding children board assures itself that perseverance is a key component of any training on child sexual exploitation and agencies ensure that cases of child sexual exploitation remain allocated even when progress may not appear to be evident.

8. The review also recommends that Calderdale safeguarding children board liaises with the adult safeguarding board to;
    a. ensure all professionals who work with young adults are aware of the issues relating to child sexual exploitation; and

b. to ensure professionals are well placed to help relevant young adults come to realise that they have been abused and are not responsible for this abuse.

Escalation and supervision

9. The review recommends that Calderdale safeguarding children board assures itself that its own escalation procedures are fit for purpose and that all child care professionals are aware of their existence and are confident in using them.

Learning from the case

10. The review recommends that Calderdale safeguarding children board, (with Jeanette's continued permission) commission a version of this report to be used with young teenagers in schools to make them more aware of the dangers of child sexual exploitation.

5.0 Individual Agency Responses to the learning from the case

Evidence of how it's different now

5.1 West Yorkshire Police:

Principally, the improvement has been around the bringing together of partners to share and discuss information about the immediate safeguarding action required and taken in respect of children at risk of CSE or who are of concern with missing incidents. The introduction of the CSE Hub to co-ordinate and task that action and the sharing of actions with wider policing family to enable better offender-focused policing have been part of this improvement. Individual perpetrators can now be assessed to verify if they are members of an organised crime group (OCG) and subject to disruption activity as appropriate.

The profile of the issue has been raised massively with frontline uniform operational officers through training and briefings to ensure that the 'signs are known' and that their knowledge of how to refer into MAST / Safeguarding unit is in place. The Missing persons coordinator is co-located within the CSE Hub and predominantly focuses on missing children. We are in the process of identifying and training single points of contact within the police to link with each of the children's' homes outside of the coordinator's working hours, to provide consistency and continuity of approach and engagement.

The main statutory and non-statutory agencies that make up the Calderdale CSE Hub are:

- Police
- Children's Social Care
- Family Intervention Team
- Youth Offending Team
- Health agencies
- PACE – Parents Against Sexual Exploitation
- BLAST – CSE support for boys at risk of CSE
- Youth Works – one to one CSE prevention and support for children

These agencies are co-located within Halifax Police Station encouraging constant information sharing and problem solving. The majority of CSE concerns and referrals are fed directly to the Hub from a variety of sources: Police led Intelligence, Social Care referrals, FIT, Early Intervention, Schools, Youth provisions or parents.

The Hub formally meet twice a week to share new referrals which are placed onto an assessment list and the CSE risk assessment is tasked out to the appropriate agency. Any immediate safeguarding concerns are shared and tasked out. A larger CSE multi agency meeting (MACSE) is held every Friday morning where children at risk of CSE are discussed and relevant actions to safeguard or develop intelligence are passed out. This includes information sharing with other agencies and other forces if necessary.

If any intelligence or information is received that a child is potentially at risk or at risk of CSE, the child is recorded on police systems as being at risk of CSE (low, medium or high). A CSE flag system shares information across the force and PNC Nationwide. Assurance is in place for children who are at risk of CSE who are moved outside of the Calderdale area (relevant police force is notified and a full handover of all intelligence and risk is provided) and for children who move into the Calderdale

area (a multi-agency planning meeting is held, including the out of force agencies to discuss the risk and trigger plans). Likewise if the child is looked after by Calderdale, Calderdale Children's Social Care shares relevant notification.

CSE matrix and meeting minutes are distributed to the Districts Inspectors to enable them to keep up to date on the current risk and the CSE Matrix is also uploaded onto a briefing item for all officers in Calderdale to be made aware.

The Detective Sergeant chairs a multi-agency Operational Steering group every 6 weeks which is aimed at first line management level to discuss CSE, children missing from home, school and education and Human Trafficking. The group reports into the strategic CSCB Proactive and Responsive Sub Group which is where the CSE Strategy and Action Plans are written, monitored, scrutinised and evidenced.

An historical multi agency audit on local CSE cases has resulted in further learning for Calderdale and a Peer Challenge across West Yorkshire on CSE and Missing done alongside the recent Joint Targeted Area Inspection (JTAI) results has been conducted; which will result in a revised Action Plan.

The single biggest outcome is the reassurance that if there are issues relating to a child or young person – whether it be CSE, missing, living in a neglectful or abusive household – that the information is submitted and a coordinated effort by partners will address the range of issues and develop the most appropriate response. Initial Child Protection Conferences, MACSE meetings, CSE hub sits next to Domestic Abuse Hub provide much improved join-up. Increasingly, positive outcomes for a child or young person are recorded on the 'occurrence enquiry log' of the police's Niche system report but we have discussed that, as free text, this is not quickly searchable, therefore we need to consider a format of reporting where outcomes can be recorded and are retrievable. But overall, the profile of the problem is much greater and our staffs' awareness, readiness and willingness to deal with it and take positive action at an early stage is much improved.

5.2 Calderdale Metropolitan Borough of Calderdale:

5.2.1 Children's Services

Children's Services in the Council deliver direct and targeted support for children and young people. The support services that include the delivery of prevention initiatives, raising awareness, delivery of targeted and direct support for children and young people at risk/victims of CSE. The service is delivered by Young Peoples Service through Youth Works and has two full time CSE Project Workers based in Calderdale.

5.2.2 Early Help Arrangements including Education

West Yorkshire wide awareness raising project work in schools fund by the Police and Crime Commissioner

- Primary and Secondary School drama performances by GW Theatre. A total of 60 performances across West Yorkshire delivered pro rata to population. Web link: http://www.gwtheatre.co.uk/
- Production of a self-contained book that does not need to rely on a child seeing the play, with home based learning activities built in
- Produce an animation of Mister Shapeshifter (Primary School performance) as a learning and training tool

Healthy Relationships support for schools. The Healthy Relationships Task Group is undertaking development work with schools to provide a reputable online resource library that all schools can access and will include recommended providers. Once this is available regular consultation will take place about how this is used and gain feedback to help keep it up to date.

5.2.3 Commissioning Services

In May 2016 the Council commissioned a support service started work with parents and carers of children and young people at high and medium risk/victims of CSE. The service is delivered by Pace – Parents Against Child Sexual Exploitation, a national charity specialised in working with parents and carers whose children are sexually exploited. The service has 1 full time Parent Liaison Officer based in Calderdale. The service also includes training professionals and developing a volunteer programme.

There is also direct and targeted support for boys and young men. Support services include the delivery of prevention initiatives, raising awareness, delivery of targeted and direct support for children and young people to meet local needs of boys and young men at risk/victims of CSE. The service is delivered by The BLAST Project, and has one full time support worker based in Calderdale.

5.3.4 Community Services CMBC

Targeted training and awareness raising is now underway within communities in Calderdale. Targeted work is delivered within the Black and Minority Ethnic community and in particular with the South Asian community. Support has been given to a local voluntary group Together Against Grooming (TAG). TAG are a Black & Minority Ethnic (BME) volunteer led group who are able to deliver CSE awareness raising using an Islamic approach as well as delivering in community languages.

A South Asian women's group made up for professionals and community members drive local activities within the South Asian community and have a local action plan to continue to raise awareness amongst BME women.

Calderdale Council of Mosques have CSE on their agenda and are working on the production of a teaching pack to be used by all Madrassah teachers with boys and young men in the community, this will reach many thousands of boys and young men. All Mosques have a designated and trained safeguarding nominee able to support and advise Mosque committees and volunteers, and be a point of contact for parents and young people.

Joint work between the Police and CMBC ensured over 1000 taxi drivers attended mandatory safeguarding training in the last 18 month with a view to engaging the taxi community as eyes and ears to support keeping children safe and encourage reporting. The training was widely welcomed and all new taxi drivers are required to attend safeguarding/professional standards training. This has become a core and mandatory part of becoming a taxi driver.

The Community Safety Partnership (CSP) recognises that the strategic lead for CSE in Calderdale sits with the Safeguarding Board, with operational delivery through the themed group. However briefings and update reports are covered at the CSP and focused work. For example last year

licensing services undertook professional standards training to all existing and new drivers. They are in the process of launching with West Yorkshire Police Vulnerability Training this will be aimed at all licensed premises, door staff, volunteers, street angels, wardens etc.

5.3 Health Organisations:

Although each health agencies IMRs identified few recommendations a great deal of learning had already been undertaken and changes to practice made. These include:

- Information with regard to spotting the signs of child sexual exploitation have been shared with all health agencies which has been cascaded to frontline practitioners and is available on the Clinical Commissioning Group's website and Intranet site which is accessed by GPs
- Mandatory safeguarding training within all health agencies now includes 'spotting the signs of child sexual exploitation'
    - Greater CSE awareness through mandatory safeguarding training (recommendation 8 of the report) - CSE is incorporated into level 1, 2 and 3 safeguarding training at CHFT
    - CSE is incorporated into level 1, 2 and 3 safeguarding children mandatory training. level 3 at SWYPFT includes a specific CSE case study and group work
    - CSE training to CAMHS and the safeguarding children link professionals including group work involving completing the West Yorkshire CSE assessment and referral form.
- Health services including CAMHS attend and contribute to the weekly child sexual exploitation Hub and share information/actions with health partners including contraception and sexual health services.
- Both CHFT and SWYPFT have representatives on the CSE Operational group
- The CCG, CHFT and SWYPFT are represented on the CSCB Proactive and Responsive sub group where CSE has been a main topic covered
- Safeguarding supervision is mandatory for all front line health practitioners including CASH services staff
- Flagging of electronic records is now in place to identify children and young people where there are vulnerabilities and cause for concern such as CSE
- Improved referral process in ED to substance misuse services for young people is being trialled. Continued use of the paediatric liaison support role to monitor cases of young people attending the department.
- Paediatric Liaison Nurse ensures all children and young people who attend ED where there are causes for concern regarding behaviours including alcohol/substance misuse or sexualised behaviours are reviewed and information shared to health agencies or children's social care and appropriate referrals made
- Contraception and sexual health services have reviewed the proforma for use with children under 18 years of age and now includes questions relating to behaviours which could identify them to be at risk of child sexual exploitation

- Work is continuing to ensure there is information sharing and improved communication between school nurse and GPs
- The acute hospital provider safeguarding team ensure all A&E attendances with cause for concern identified are shared with school nurses with any actions required
- The GP in this case did not review A&E attendances by children and young people – The GPs now review all A&E attendances by children – this was implemented immediately it was highlighted during the writing of the IMR by the Named GP in Calderdale.
- NHS England have a CSE National Working Group for CSE and this is attended by the Designated Nurse from the CCG and also the Assistant Director of Nursing, Governance and Safety from SWYPFT

5.5 National Probation Services (NPS)

The National Offender Management System has recognised that the numbers of men convicted of CSE offending will increase, and is developing training materials designed for Probation Officers who are working with perpetrators of CSE. These materials will assist in identification as well as the management of these offenders. There is also the 2 day mandatory training that is being rolled out on domestic violence and child safeguarding, which specifically covers CSE, child trafficking and honour based violence, as well as local SCB and or police led training that NPS can access.

6.0 How the Board will oversee and ensure that the recommendations are acted upon

a. The CSCB partnership will ensure that areas of improvement to joint working practice are reflected in the revision of the Business Plan as appropriate. This will take account of, but not be limited to the robustness of policies, procedures, local guidance, training and the impact of these on front line practice.
b. Progress and impact will be managed through the appropriate CSCB work streams, with the Case Review sub group monitoring an overarching action plan.
c. The CSCB and its members will formally and regularly monitor the implementation of the action plan and recommendations in order to ensure progress is being made
d. The CSCB Case Review sub group will maintain a register of all recommendations and require both the CSCB and its partner organisations to report on progress on a regular basis
e. The CSCB performance management framework will be changed to reflect in its core indicators key areas of learning so that compliance can be evidenced
f. The CSCB multi agency case file audit programme will be revised to reflect the learning from this case to test out changes to front line practice and line management
g. The CSCB multi agency training programme will be amended to reflect key learning and will be reported to the Board in annual and quarterly evaluations.
h. The CSCB will review policies and procedures and where necessary update or put in place appropriate amendments or new policies
i. The CSCB, in its annual report, will report on the progress made and the wider impact across partners of the learning, in order to consider whether progress and impact has been good enough
j. The CSCB, through the Independent Chair will escalate national recommendations to the Secretary of State, the National Panel of Experts and report progress to the CSCB
k. The CSCB will work with partners to progress the single and multi-agency recommendations
l. A Challenge Event will be held after 6 months from the date of publication to test out the sustainability of the changes made as a result of this SCR. Learning from this will be reported to the CSCB.

6.1 Dissemination, implementation and monitoring of impact of learning

The Board and its partners have a number of mechanisms to ensure satisfactory dissemination of learning. Across the safeguarding partnership we have a culture of continuous learning and improvement. This must be sustained and we will test this through regular monitoring and review. Our approach to this is outlined in the Learning and Improvement Framework; these are some examples of how the learning from this review will be promoted and embedded in practice:

- Training and briefings to professionals and young people
- Newsletters, briefing papers and learning lessons for front line practitioners
- Quality assurance through audit
- Performance management of indicators which outline practice improvements
- Publication on website
- Challenge events for front line practitioners to ensure the learning has been absorbed

7.0 Summary from Independent Chair

The Calderdale LSCB partnership commissioned this review as an important part of its ongoing response to supporting the partnership joint working response to children who are sexually exploited or at risk of sexual exploitation.

Partners and the partnership have worked over the last 3 years plus to ensure that there is a robust and resilient approach to CSE and child sexual abuse. The Board and its members have to supported, scrutinised and challenged each other and the wider system approach. This has not just been to be assured the arrangements for protecting children and in particular those who are most vulnerable, are as they should be. It has also been to ensure that partners are responsive to learning and what victims and young people are telling us.

This review was seen as an opportunity to look, with the benefit of hindsight, from the perspective of "Jeanette" a time in her life when arrangements to protect her failed. It has therefore provided all concerned with an opportunity to reflect and seek assurance that things are different now.

As a partnership we are always ready to acknowledge and take responsibility for any occasion when a child or young person suffers harm or abuse, and this review, its terms of reference, has been independently chaired and delivered. In addition the board has sought to ensure that this has been a robust and thorough review.

The review also will help all to better understand not just how professionals see things but also how children see them. The review contains some important messages and imperatives to ensure we do all we can to close any gaps between these different understandings.

The review also helps us to better understand the difficult and complex issues around religion, backgrounds and how when abuse occurs, we all find it difficult and challenging to recognise that such things can happen in our community or organisation.

It may feel that we know a lot about Child Sexual Exploitation, and this review helps to further our understanding of this form of abuse and exploitation. It rightly reminds us that the consequences of any form of abuse or exploitation are something we should never stop being shocked by.

Partners and the review itself have recognised in a transparent way that there remains much to be learnt and improved. The review is also unequivocal that the LSCB and wider "partnerships" including central government need to continue their efforts. It also is clear about what the LSCB partnership needs to take forward in terms of supporting, promoting and monitoring the effect this learning has on current and future practice and joint working arrangements.

It is proper that we should all be reminded of the tragedy that is abuse of a child by adults, and this review powerfully and intentionally makes sure that Jeanette's experience in her own words is shared. This can create very strong reactions that often result in feelings of disbelief, anger or shame. The report helps all those concerned to work through these understandable reactions in order to help us to focus our efforts and look to be ever more vigilant.

Anyone that reads this review cannot fail to be moved, it is of note that partner agencies are able to share and reflect on their roles and any shortcomings. The review whilst helping us to understand the missed opportunities and setting these against how things are now, also provides some direct and powerful messages.

Perhaps the most powerful of these is those that come from Jeanette herself, the role that some key individuals played, such as her foster carers, a police officer and her current social worker. Each of these demonstrated the capacity to have faith in Jeanette, but to be able to exercise some influence on joint working practices.

We should note that Jeanette was at time lost to another world of experiences and abuse for much of her childhood, and this must remain a cause of concern for all the adults that knew her and had responsibilities. The review notes that Jeanette has exercised maturity and understanding, and at times has chosen to spare us some aspects of her experience.

Reviews of this nature should and do raise a series of questions, such as “what would I do if I found myself in that position?”. “If only I knew then what I know now”? The terms of reference were the starting point for how we wanted the review to address these sorts of questions. The review report and the LSCB response will be guided by and judged by how successfully the learning results in measurable change for the better.

It is I feel appropriate to also comment on the courageousness of Jeannette and a number of professionals each of whom has felt able to stand up for, often at some cost, for what they feel is right. We should feel humbled by this but also inspired to follow their lead.

Richard Burrows
Independent Chair
Calderdale Safeguarding Children Board