**Child Practice Review Report**

**Western Bay Safeguarding Children Board**

**Extended Child Practice Review**

**WB S 18 2015**

## Brief outline of circumstances resulting in the Review

Legal Context:

An Extended Child Practice Review was commissioned by The Western Bay Safeguarding Children Board (WBSCB) on the recommendation of the Child Practice Review Management Group (CPRMG) in accordance with the Guidance for Multi-Agency Child Practice Reviews. The criteria for this Review were met under section 6.1 of the above guidance namely:

A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

(a) Died; or
(b) Sustained potentially life threatening injury; or
(c) Sustained serious and permanent impairment or health or development

and

the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

- the date of the event referred to above
- the date on which the local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development

*The criteria for extended reviews are laid down in revised regulations, The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012*

In this Child Practice Review Report the parents are referred to as “mother” and “father”. The children of the family are referred to as Child and Sibling.

**Family Background**

The child subject to this review is a foreign national. Parents separated when she was born. She lived with her grandmother, mother and an aunt in the family home. Mother said she worked long hours and as a result, the child spent much of her time with her grandmother and other relatives.

The child was described as a happy child but outspoken and confident from an early age. She would show jealousy towards her cousins if they were given attention. She was described as a busy child however responded to boundaries in general. Mother reported that in her homeland children are brought up to respect their elders and punishment for failing to do so is often physical chastisement.

The child has only met her biological father once during her childhood. She has some recollection of this meeting and would like to know more about him and his life but Mother will not speak about him

Mother met her current husband, (the only father figure that the child has truly known, and referred to in this report as Father), when he visited her country of origin. Mother came to the UK for two months to spend time with Father and during this time she became pregnant with the child’s sibling.

The child remained with extended family in her homeland and Mother was married as due to embassy requirements the child did not have permission to live here until this happened.

Mother reports that although Father made every effort to treat the child as his own child, she was jealous of his relationship with Mother.

Mother reports that she and Father disagreed on parenting styles. Mother tended to be strict and used physical chastisement to manage her daughters behaviour, whilst Father would give in to her demands by, for example, giving her money.

The child was referred to Social Services in the winter of 2012 by Father due to deteriorating family relationships which he reported had been difficult since the Spring of that year but were now broken down. The child was reported to be becoming beyond parental control. She was staying with a friend temporarily and Mother would not allow her to come home and wanted to send her back to her home country. Father and Mother had recently started their own business.

For the next six months or so there was a pattern of incidents in the family home where the child and her Mother were involved in arguments which escalated to the point of violence. Friends provided periods of care/respite but these would be short lived because of commitments or difficulties managing the child’s behaviour.

Initially reluctant, Mother did accept support from Family Support Services, and

although at times the home situation would improve, overall the pattern continued until the child was accommodated in March 2013.

## Circumstances Leading to the Review

This review was commissioned because during the timeframe of the review the behaviour of the child concerned has made her increasingly vulnerable to sexual exploitation. These behaviours included over 40 episodes of absconding from her home or placement. She has admitted to sexual activity with numerous men where the ages have been between late teens in the early period of the review, to men in their 40's towards the end of the period of the review. Her resourcefulness has meant that she has absconded to towns and cities where she made herself vulnerable to serious risk of significant harm and moral danger. Her escalating behaviours have also included the use of both drugs and alcohol and violence against care staff. Her vulnerability is increased because she does not perceive herself as a victim but rather as a person in control. She considers that she is making informed choices in relation to her behaviour.

## Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the WBSCB.

- Examine inter-agency working and service provision including periods of secure accommodation, out of area provision and return to the area for the child and family.

- Determine the extent to which decisions and actions were child focused.

- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress. Take account of any parallel investigations or proceedings related to the case.

- Hold a learning event for practitioners and managers and identify required resources.

**For extended reviews ONLY.**
**In addition to the review process, to have particular regard to the following**:

- Was previous relevant information or history about the child cultural issues or changes and family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances? How did that knowledge contribute to the outcome for the child?

- Was the child protection plan (and the looked after child plan or pathway plan) robust, and appropriate for that child, the family and their circumstances?

- Was the plan effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?

- What aspects of the plan worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked? Were the respective statutory duties of agencies working with the child and family fulfilled?

- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues including culture, language and understanding?

- Were the statutory duties of all agencies fulfilled?

**Specific tasks of the Review Panel**

- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline commenting on appropriate practice and its impact on the on-going work with the child and an initial case summary and identify any immediate action already taken.

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s a learning event for practitioners and managers, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

- Plan with the reviewer/s contact arrangements with the child and family members prior to the event.

- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the SCB for consideration and agreement.

- Plan arrangements to give feedback to family members and share the

contents of the report following the conclusion of the review and before publication

**Tasks of the Western Bay Safeguarding Children Board**

- Consider and agree any Board learning points to be incorporated into the final report or the Action Plan.
- Review Panel to complete the Report and Action Plan before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on WBSCB website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the WBSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed referring to the agreed WBSCB Media Protocol.

It was confirmed that the scope of the Review should be from 1st March 2013 the date on which the child was accommodated until 28th February 2015, when the Child Practice Review Management Group agreed the criteria for a review was met. .

Following the decision to carry out a Child Practice Review a Child Practice Review Panel was formed;

Chair of Panel - Amanda Hinton, Child & Vulnerable Adult Safeguarding Officer, Education, Leisure and Lifelong Learning Service Neath Port Talbot
Internal Reviewer – Daphne Rose – Designated Nurse, Safeguarding & LAC.
External Reviewer – Karen Burrows – Service Manager, NSPCC

**Panel members**

| **Agency** | **Designation** |
|---|---|
| Local Authority | Head of School Support Unit |
| Local Authority Children's Services | Service Manager |
| Local Authority Legal Services | |

| | |
|---|---|
| South Wales Police | Protecting Vulnerable Person Manager |
| Barnardos | Assistant Director for Children's Service South East Wales |
| Abertawe Bro Morgannwg University Health Board (ABMUHB) | Clinical Nurse Specialist Safeguarding Children |
| Western Bay Safeguarding Children Board | Strategic Business Manager |

Two learning events were convened, one for practitioners and one for managers. The practitioners learning event was attended by 58 members of staff from the following agencies:

- South Wales Police
- Social Services Dept
- ABMU Health Board
- Education Dept
- Priority Childcare
- Child &Adolescent Mental Health Services(CAMHS)
- WAST – NHS Direct
- Secure Unit

The managers learning event was attended by 29 members of staff from the following agencies:

- South Wales Police
- Education Dept
- Social Services Dept
- ABMU Health Board
- Barnardos
- Priority Childcare
- Child &Adolescent Mental Health Services(CAMHS)

The Terms of Reference required that:

> "The family will be contacted at the appropriate time by letter informing them of the Board's intention to undertake the review and make an appointment to visit to provide an opportunity to discuss the matter…."

The Reviewers met with Mother, Father and Sibling at their home.

The Reviewers met with the child in her placement as the Child Practice Review Panel wished to ensure that the voice of the child was heard in this report.

In accordance with the Terms of Reference legal advice was available should it have been needed.

## Practice and organisational learning

This Child Practice Review has examined thoroughly the circumstances and issues that have arisen in this complex case. The events that led to the need to carry out a Review occurred from March 2013 to February 2015. However, it is an unusual review in that work with the child and family continues with on-going interventions and grave concerns for her safety and wellbeing remain.

### Working With Families

It is recognised that this has been and is a very challenging case for all the professionals working with this child and her family.

**Parenting styles/ lack of consistency in parental messaging to both professionals and the child/ perceived cultural issues /physical chastisement**

The parents did not appear to agree on the parenting of the child which led to inconsistencies in the manner to which she was parented. Mother had a tendency to resort to physical chastisement which resulted in the child being subject to a child protection plan under the category of physical abuse. It is clear she advocated this style of parenting and also said on occasions she would send her daughter back to her homeland so she could be 'beaten'. This view of parenting as expressed by mother was recorded but there is no evidence from the files that there was any investigation into the cultural norms for physical chastisement in her home country. It is clear from a very brief review of the literature of her home country that corporal punishment is not against the law in the family home at this time albeit they are, as in the UK, working towards such an aim. The wording is similar in that it says *"to punish a child in a reasonable manner for disciplinary purposes".*

The Father on the other hand was less strict and it would appear he was more likely to give the child money and expensive items such as a mobile phone. Such an item is common place for children in this country, and like many children this child was 'technically able' and communicated with others through numerous chat rooms etc. putting her at risk of harm especially child sexual exploitation (CSE). The use of her mobile phone or computers appears not to have been monitored by her parents.

**Family Compliance / Lack of ability to comply with a plan**

The family appeared to find it difficult to work with plans put in place to safeguard the child. In many ways it would appear they were unable to implement the strategies put in place to manage the child's behaviour and the child took control. For example when the child was accommodated under s.20 there were occasions when the child did not return to placement after a visit to her family. This behaviour appeared to be condoned by the child's parents which continually undermined the plans to keep her safe.

**Opening of Family Business: a Catalyst for change**

Both the family and the professionals recognise that the starting of their family business was a catalyst for change in the way the child's behaviour changed. The long hours the parents worked meant the child was left unsupervised in the evenings and this lead to the changes in her behaviours. She became demanding for material things, which were invariably given to her. This included money as well as gifts. It is also worthy of note that during her primary years there were no negative reports from school and this did not become an issue until she started at senior school, where her behaviours have resulted in exclusions (8 exclusions in total between December 2012 and February 2014. Maximum exclusions were 3 days).

**Family History**

During the assessment process the family history appears to have been taken from the parents as to how they met and married. However the child's version of the family history in her homeland is quite different and significantly so in some aspects, yet this seems not to have been explored. If it had been, it may have resulted in a different focus on the assessment of her formative years. Mother is recorded as saying she worked in a factory, however the child reported mother worked in a bar late into the evenings and men were often around. It could be both are accurate but the child only had knowledge of the latter. It is essential a child's recollection of her family history is taken just as seriously as the mothers and appropriately explored. The history she describes could have influenced her behaviours which escalated at the time the family business was opened. Her behaviour is very different to her sibling, who is a quiet and compliant child and clearly adored by both parents. This child appears to crave love. It is also apparent that despite her being able to articulate that she sees her younger sibling as the favourite child, she clearly adores and misses her.

**Family secret**

The child spoke about a 'family secret' to an agency working with her, and this was shared with partner agencies. However it appears no one ever got to know what this secret was, and whether it was a 'positive' or 'negative' secret. The child may have wanted to disclose what the secret was, but perhaps needed more encouragement to do so. It is not evident from the files this was the case, or clear what attempts were made to find out the nature of the secret.

**Engaging with Children**

This child believes that she is in control and has developed a resourcefulness that enables her to push the boundaries to the limit. She believes she is in control of her own destiny. She told the Reviewers that she considers it is her fault that one of her abusers is in prison. She believes that when he is released they will be re-united as 'they love each other".

It was clear to the Reviewers that she can be very demanding of professionals' time, and the demands are very much on her terms. She is an articulate girl who can express herself clearly even though it might not be what professionals want to hear. She can also be selective in regards to what she chooses to hear.

**Pushing the boundaries to make people listen/ sees herself as the exploiter**

The child continually pushed the boundaries and was very resourceful in managing to run away and get to other areas quite quickly. Such behaviours have put her at considerable risk. It may be possible to suggest that her behaviours are attention seeking, but likewise it is possible she seeks attention because she needs attention. For example during the latter stages of the review period her self-harming behaviours escalated.

Despite the efforts of all those working with her she does not believe she is a victim of child sexual exploitation and sees herself as being in control of the situation. However it is of grave concern that as she gets older the age differential between her and the men who are exploiting her gets wider. At the beginning of the review period the men were in their late teens and early 20's, however now her exploiters are in their 30's and 40's.

**How we mitigate against losing learning when the publication of the Report is delayed**

There are times when the publishing of a report is delayed for legitimate reasons but it is essential the learning from this case is shared as soon as the WBSCB accepts its findings. The learning will not change even if publication is delayed.

**Case loads**

Practitioners working with the child were presented with a high level of complex and challenging situations; this meant that an increased resource was required which effectively reduced capacity to work with other cases.

This was addressed in different ways by different agencies. There are a number of practice areas to highlight:

- The police dedicated a support team of officers to assist in safeguarding the child which helped to facilitate her disclosures and they investigated all identified offences
- Social Services were able to offer a degree of continuity in the social worker allocated to the child's case and despite the complexities of the case there have been fewer changes of social worker than in other cases. The social workers caseload was reduced in number, in recognition of the time required to be allocated to protecting the child.
- Education dedicated some pastoral support to address concerns with the child once early indicators of CSE became evident.
- The care home placements provided additional staff to provide surveillance in their endeavours to keeping her safe.

However, despite best efforts of these and other agencies, the child continued to place herself in risky and dangerous situations, and managing these behaviours was very challenging in terms of time and resource for practitioners working with her. Practitioners identified the importance of Managers recognising these challenges and ensuring consideration is given to the caseloads of practitioners working with such complex cases

**Information Sharing**

It was apparent at both the learning events that not all information was known to all services. Practitioners highlighted that referral information was sometimes incomplete and didn't fully identify the risk and danger presented by the child. Practitioners recognised that having an integrated information/chronology system would have ensured that all staff working with her would have been kept fully informed. This may also have informed practitioners and enabled them to instigate Sexual Exploitation Risk Assessment Framework (SERAF) processes much earlier on. It was evident that her risky behaviours were escalating but the processes and practices to deal with the risky behaviours did not result in escalating interventions. When referrals were made to one particular support service, due to lack of engagement by the child the service was closed down. This was at the start of the long summer school holiday it meant that she was particularly vulnerable and without support for this extended period. Consideration does not appear to have been given to the need for continued support to the family during this period. It was also highlighted that she had now moved placement completely out of the Western Bay Region and there was uncertainty as to whether all agencies in the new area were alerted to the child's ongoing behaviours and needs.

## Child Sexual Exploitation(CSE) Processes

There were a number of processes being followed in respect of the child and the practitioners expressed their concerns that following parallel processes, such as Looked After Child (LAC), Child Protection and Child Sexual Abuse/CSE, may impact on the level of holistic assessment required to work effectively with the child.

This was further complicated by her coming in and out of the LAC system a number of times, even within the early part of the timeframe visited for this review. In addition to this, early child protection conferences were not alert to the increasing sexualised behaviour being displayed by the child and she was initially registered under the category of physical abuse. Once the situation became clearer practitioners felt that a further child protection conference should have been convened to consider changing the category of registration and amending the plan accordingly.

Practitioners also felt that by accommodating the child under Section 20 of the Children Act 1989 and leaving parental responsibility with her parents, inadvertently empowered her to continue to make dangerous choices and influence her parents decision making. Although practitioners felt given the complexities of the case and the challenges in keeping her safe, even if the care order had been made earlier it would not have been able to effect the change needed in her behaviour to fully protect her. At the managers learning event it was agreed a care order should have been considered sooner.

## Sexual Exploitation Risk Assessment Framework SERAF

Practitioners commented that at the time there was a lack of understanding around the use of SERAF assessment and how to understand and interpret the score. There was also a discussion around identifying when sexualised behaviour triggered a CSE Strategy meeting. Practitioners felt further understanding of the SERAF assessment tool is needed. Clarity is required to help identify as which point in a SERAF assessment legal action should be taken. It is considered the continuity of worker undertaking the SERAF assessment is important and would have assisted practitioners in safeguarding and protecting the child. It was noted numerous practitioners undertook the completion of a SERAF assessment and how the scores changed quite dramatically within a few days. The importance of practitioners having training in the use of SERAF was discussed at a Panel meeting with varying views as to who had or had not been trained in the use of the SERAF. In addition it was identified that Health do not use the full SERAF tool but have in some areas recently introduced a validated shorter version -CSERQ15. This is an assessment tool specifically for use by health staff so that they are able to make a decision on whether to refer to social services because of concerns about sexual exploitation. Following the referral the CSERQ15 is not a replacement for SERAF. It is also hugely important that full referral history, including sexual concerns are made known and clear to any practitioner undertaking the SERAF assessment.

It became apparent at the Learning Event that referrals are made for CSE strategy meetings by individuals who have not received training around CSE or SERAF.

This child was 12yrs old at the start of this review, and under UK law a child under 13yrs is deemed unable to provide consent to sexual activity, only the child's age and the act itself is needed to be proved to proceed with criminal action. Practitioners felt that taking legal action to initiate care proceedings could have been explored much earlier on in the process, although it was accepted there would still have been difficulties in commencing any criminal processes as the child was refusing to give consent for a child protection medical. This caused further dilemmas and frustrations for practitioners who were endeavouring to protect her. If there had been consent, a child protection medical could have lead to DNA samples being available which may have then been sufficient for a prosecution without the child needing to give evidence.

**Sexual health**

Practitioners working with the child, particularly those working in the care homes she resided at, reported difficulties in arranging and attending appointments at sexual health clinics for her. It was noted that encouraging her to attend and wait for a service was challenging, but these challenges were further exacerbated by her controlling the level of information she shared with clinic staff. Practitioners identified that there was no opportunity to be able to share relevant and important information about the child freely as she was always present when professionals met and she would only partially disclosed information at her appointments. It is noted that if it is in a child's best interests it is justifiable to share confidential information. Practitioners should be aware that if such information is shared to safeguard the child it is necessary the decision to do is accurately recorded in the records

At the learning event the practitioner from the sexual health clinic put forward some ideas that could drive important changes and ensure greater support for young people. The changes would also facilitate professionals being able to maximise the opportunities to safeguard and protect young people.

- Practitioners are able to book a same day appointment at a sexual health clinic for young people via telephone. This telephone call will enable practitioners to share relevant and appropriate information freely.
- Sexual health practitioners offered to arrange to undertake a visiting service to young people in care homes, but not as routine practice.

This problem solving approach driven by the practitioners from the sexual health clinic was a really positive input into the learning event and will facilitate change in practice which will support professionals to better protect young people in the future.

- Currently booked appointments to clinics are possible on certain days and relevant information can be shared with the sexual health staff by contacting one of the Lead Nurses or Health Advisor who works part time.
- There is an outreach nurse who will visit children and young people in placement if they are resistant to attending the clinic but this would only be in specific circumstances.

## CAMHS

There were, and still are, on-going concerns for this child's mental health. Care staff made 24 calls to NHS direct in respect of her. The majority (14) of these were in respect of her self- harming behaviours. She received health intervention from child psychologists at the secure unit, the LAC health team, and a clinical nurse specialist for LAC. Practitioners considered the child used a series of self-harming behaviours to create opportunities to abscond. They also expressed that she appeared to enjoy the increased attention from her mother at these times.

Practitioners at the learning event discussed the thresholds for CAMHS intervention. Despite her increasingly risky and dangerous behaviours the child refused to engage with CAMHS and therefore has not received any medical diagnosis in terms of her mental health.

Practitioners were uncertain as to who is actually able to make a referral into CAMHS, with some practitioners believing referrals could only be made by GPs and others believing referrals could only be made by GPs or social workers. CAMHS practitioners were able to confirm that any professional could refer into CAMHS, and also provided reassurance to professionals at the learning event that they had appropriately understood the child's needs and the services available to her.

CAMHS advised the learning event of a new 24 hour CRISIS service which is currently being recruited to. This will mean when the service is in place that any child or young person in crisis who attends the Accident and Emergency department because they have self-harmed or attempted suicide will have a mental health assessment completed in the Accident and Emergency department and following this a decision can be made about discharge home with the intensive support provided by the new service. (If the child or young person requires medical treatment or admission to a specialist mental health unit they will require admission to hospital).

This was commended at the learning event as being a really positive step forward and one that will provide children and young people with increased support at the time of crisis. The level of support provided by the new service will enable children and young people to return home and avoid the need for admission to hospital. However, there was concern that this new service could potentially be overwhelmed by demand. It was confirmed that this new service is a crisis point intervention and not a therapeutic type intervention.

## Police

The response by Police was both proactive, in terms of the team assigned to the child by senior managers, and reactive, in terms of the costly resource of police hours involved in locating and transporting the child home after each time she went missing. During the timeframe of this review she went missing more than 40 times and so responding to this in itself was highly challenging.

The difficulties of the police response were evident as practitioners discussed the challenges of engaging young people in cases where they are not disclosing evidence and are refusing medical examination. Nevertheless there have been some prosecution successes as a result of the commitment to engage with the child in the criminal processes and convictions have been secured in a number of cases. It is, however, absolutely clear that she only engages with any service completely on her own terms and therefore the fact police have successfully engaged her as a witness in criminal action is an achievement.

There have also been practice improvements in police ability to respond in these situations, as there is now an established CSE advocate (Barnardos) in place who can debrief and work with young people.

Therefore there appears to be a level of uncertainty as to whether the numbers of referrals are consistent with the numbers of young people who are at risk of CSE.

**Multiple Placements**

There was a recognised difficulty in being able to locate the type of placement that would fully meet this child's needs. She has experienced a number of foster placements and resided in a number of care homes and secure placements. It was a recognised challenge for the social worker to find appropriate foster carers. Some placements were refused by the child and other foster placements seemed to work well initially but then ultimately failed usually due to the child being unable to cope with boundaries put in place or refusing to return to the placement after a visit to her family. A placement with young and newly assessed carers was discussed at the learning events as a questionable decision, but transversely it was this placement which the child settled in to the best and this young inexperienced carer seemed to achieve the greatest connection with the child. She moved placement eight times during the period of this review. The moves were motivated by her and her escalating risk taking behaviours. She was recognised as being influenced by others and also influencing others.

The child is now in a placement some four hours' drive away from her family and as expressed to the Reviewers this is a source of great upset and frustration to both the child and her parents. It also requires additional time and resource from her social worker. Nevertheless, this is believed to be the best place to meet her needs over the period until she reaches 18 years of age. Whilst it is agreed that to be such a long way from home for a young person of 15 this may be the best opportunity to date for her to be kept safe and for her risky behaviours to be minimised.

**Education**

Education staff reported no significant or concerning incidences in the child's life up until the point that the family business was set up. Her parents also confirmed this view to the Reviewers. It is noted that when the parents were attending to the business it resulted in inconsistent parenting and them being significantly absent from the child's life and she spent increasing amount of time alone at home. This in

turn impacted upon her education and her behaviours started to deteriorate at school around this time. Increasing and escalating incidences, together with situations which alerted staff to potential child sexual exploitation, were being addressed by the school and there were determined and increased attempts to re-engage her into the school ethos and values. Ultimately, her behaviours caused such severe disruption to school life that this resulted in a series of exclusions. However, the exclusions then resulted in longer periods of time spent alone at home. Her risky behaviours continued to escalate and she was registered with Education Other Than at School (EOTAS) provision from January 2015

**Cultural issues / working with foreign nationals**

**Lack of background information**

This is the second Child Practice Review WBSCB has undertaken in relation to a foreign national (completed but unpublished at the time of this review). It is noted there have been similar findings in both reviews.

- It appears there is no reliable way to discover details about backgrounds that in other circumstances would be available and essential in carrying out any assessment of risk of the safety of young children.

- Assessments that took place relied on the parents' accounts of their lives in their country of origin and on occasions were very different to the child's recollection of what life had been like in her home country. It appears from the records this was not explored further.

- No medical histories were available.

- It appears that if something is not known there is a tendency "to assume it is ok". This is not safe practice.

- Professionals need to test the presentation and accounts given by parents.

Accessing background information is important, even more so when this is held outside of the UK. Not seeking such information was identified as a risk in a recent CPR (WB 6/2013), that was commenced by Swansea Safeguarding Children Board and completed by Western Bay Safeguarding Children Board.

Cases involving families or some members of a family who are from countries other than the United Kingdom give rise to additional issues. (See The Climbié Report 2003; the All Wales Child Protection Procedures 2008).

The importance of establishing clear arrangements to gather appropriate family history and historical information will increase as the number of families coming from other countries to live here increases.

**Inter-Agency Issues**

It was widely recognised, at both the manager and professional learning events, that the demands on services and agencies of endeavouring to keep this child safe and protected have been huge in terms of time and resource. Practitioners voiced that the intensive level of support required for this child and her complex needs impacted on the time available for other cases and work.

All practitioners and managers involved in the review spoke with genuine warmth and regard for this child. The learning event discussions pointed to very committed practice by professionals, who all were endeavouring to affect change in this child's life and ensure her on-going safety.

There was also an indication of a crisis management which was reactive rather than proactive in thinking whereby decisions were made 'hoping' for the best outcome'. There also seemed to be widespread sense of professional helplessness as participants expressed an underlying belief that, despite the best efforts of everyone involved, this child is ultimately the master of her own destiny.

There was recognition that until she reaches the age of 18 she will be managed as a victim of CSE. However professionals are concerned there is a danger that if her behaviours don't change, there is a potential she could be seen as a perpetrator of CSE.

**Improving Systems and Practice**

This review has identified, in this case, there were inconsistencies in the interpretation, understanding and use of the SERAF tool including failure to recognise CSE. Upon considering how to improve systems and practice the Reviewers considered the need to re issue SERAF guidance, assure the Board on the role out of training and an understanding of demand and service supports in place locally and regionally for children at risk of CSE.

Prior to the completion of the report however, Welsh Government has issued an extensive CSE action plan which incorporates the recommendations considered above and many more to ensure a robust holistic approach and response to CSE. Across the region this has been cross referenced with agencies' work on compliance with the Bedfordshire CSE assessment standards. On this basis the following recommendation is issued:

The WBSCB should ensure standards within the CSE action plan (WG and Bedfordshire combined) are implemented in accordance with timescales set.[1]

[1] The CSE action plan (WG and Bedfordshire combined) can be accessed via the WBSBs' Business Management Unit: www.wbsb.co.uk

**Reminders of Expected Practice**

- In order to work effectively with families a full and thorough understanding of the family history is essential. This is especially so when it involves foreign nationals. When there are concerning presenting factors, it is important to investigate whether there is any basis or not these are due to cultural norms reported by the family that should be challenged.

- If a child's perception of the family history is different to that reported by the parents this needs to be explored. It must not be assumed the parent's version is the correct one. Again this is especially important when it involves foreign nationals and every effort must be made to clarify the facts

- Social Work Managers should always endeavour, as they did in this case, to reduce practitioner caseloads to an appropriate and manageable level with complex cases. This should help in enabling practitioners to undertake the most appropriate practice across the breadth of their case load. Support is needed in the most complex cases, which must be allocated accordingly to the skills and experience of the practitioner.

- At the point of referral any professional/agency referring to supportive services should always ensure in depth information and a complete chronology highlighting the historical involvement of the family with their service.

- It was recognised that this child's experiences resulted in behaviours that presented many challenges to those trying to work with her to effect positive change. As professionals, it is important to be mindful that for some children they see their behaviours as a solution to their problems, especially when it comes to placement breakdowns.

- The appropriate timing of closing cases involving children and young people should always be considered. Agencies should endeavour not to close cases during periods when young people are already facing an extended period without professional support. The possible impact on the family (such as school holidays) must be considered. In addition it is essential that agencies are fully updated of any changes that have occurred during a period of non-involvement

- When young people are moved from one to region to another, information should be shared with the agencies in the new region promptly and with other agencies involved in the Western Bay Region, initially by phone call and confirmed in writing. The Looked After Children health team were noted to transfer information in this way to other areas within their own agency.

- The All Wales Child Protection Procedures make provision to reconvene a review Child Protection Conference when there is a significant change of circumstances or further incident of significant harm (etc.). When a child on the Child Protection Register becomes subject to a CSE strategy meeting consideration should always be given to reviewing the category of CPR

registration and the Child Protection Plan to incorporate appropriate response to CSE concerns.

- Practitioners working with sexually active young people should be able to access training and utilise the existing tools that have been validated to assess the severity of the risks to CSE. It is important the tools actively influence the care planning process.

- Legal advice and guidance can be sought as to whether there is any possible action available to practitioners when parents or carers refuse consent for medical examination when it is considered to be in the child's best interests such as a child assessment order, however if the child refuses consent and is Fraser competent, the lack of consent stands and we would not be able to enforce a medical on the child.

- In complex cases such as this practitioners and managers across all agencies are reminded of the importance of appropriate and timely supervision.

- Practitioners are reminded that to share confidential information about a child which is considered to be in the 'child's best interests' is justifiable. Such decisions must be accurately recorded in the child's records

- Education and senior leaders in schools should try to seek to find a more appropriate and supportive means to exclusion in the case of pupils who are already isolated and vulnerable. An alternative means should be sought and partner agencies must be informed if they are excluded so they know the child is out of school

- Legal Advice should be sought when concerns are escalating to ascertain what options maybe available

The following recommendations from WBS6/2013 are also appropriate to this review

Any training, other learning provision and practice guidance developed by Western Bay Safeguarding Children Board concerning child protection cases involving children and families from outside the United Kingdom should include reference to:

1. The need to secure as much information as possible regarding the family background or that of an individual, wherever it exists.

2. Guidance on how to access information held outside the United Kingdom.

3. The need to ensure that if information is not available there is not an assumption that the history is positive.

Dissemination of Learning

Western Bay Safeguarding Children Board should consider:

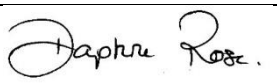
1. How the learning from this Child Practice Review and others involving foreign nationals might be shared and the impact on improving practice maximized not withstanding any reporting restrictions.

2. Arranging a conference, seminar or other learning event to assist disseminating the learning from these Child Practice Reviews.

3. Including in any conference, seminar or learning event experiences from other cases and in other areas so far as language and cultural issues are concerned.

4. Including in any conference, seminar or learning event the need to guard against early optimism inappropriately influencing the consideration of future events.

| **Statement by Reviewer(s)** | | | |
|---|---|---|---|
| **REVIEWER 1** | | **REVIEWER 2 *(as appropriate)*** | |
| **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | | **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | |
| I make the following statement that prior to my involvement with this learning review:-<br><br>• I have not been directly concerned with the child or family, or have given professional advice on the case.<br><br>• I have had no immediate line Management of the practitioner(s) involved.<br><br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. | | I make the following statement that prior to my involvement with this learning review:-<br><br>• I have not been directly concerned with the child or family, or have given professional advice on the case.<br><br>• I have had no immediate line management of the practitioner(s) involved.<br><br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. | |

| | | | |
|---|---|---|---|
| • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. | | • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. | |
| **Reviewer 1** *(Signature)* |  | **Reviewer 2** *(Signature)* | |
| **Name** *(Print)* | DAPHNE ROSE | **Name** *(Print)* | KAREN BURROWS |
| **Date** …….…… | | **Date** ……..……..…… | |
| *Chair of Review Panel* ……. *(Signature)* **Name** *(Print* ……. **Date** | | | |

**For Welsh Government use only**

Date information received ……..

Date acknowledgement letter sent to LSCB chair …….

Date circulated to relevant inspectorates/Policy leads …….

| **Agencies** | **Yes** | **No** | **Reason** |
|---|---|---|---|
| CSSIW | ☐ | ☐ | |
| Estyn | ☐ | ☐ | |
| HIW | ☐ | ☐ | |
| HMI Constabulary | ☐ | ☐ | |
| HMI Probation | ☐ | ☐ | |

q