Rochdale Borough Safeguarding Children Partnership

Serious Case Review

‘Olivia’

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1. Introduction

This Serious Case Review (SCR) was commissioned by the Rochdale Borough Safeguarding Children Partnership (RBSCP) on 18/04/19. The decision to conduct a SCR was made following a rapid review of the circumstances of the case and advice from the National Child Practice Review Panel that the criteria had been met for a SCR to be commissioned in line with Working Together 2018.

The catalyst for this review was that a 14-year-old girl who had been coerced into a sexual relationship with a 34-year-old male who was an old friend of the child's brother and had been known to the family for several years. The child will be known as Olivia, this is not the child's real name to protect the child's identity. Olivia had in the past experienced domestic abuse, parental substance misuse, parental mental health issues leading to various levels of neglect throughout her life.

Olivia is a pseudonym chosen by the Independent Author to protect the identity of the child.

The key learning themes identified in this review include**; recognising child sexual abuse /exploitation; impact of adverse childhood experiences; adolescent neglect and safeguarding arrangements.**

2. Methodology

The methodology for this review was carried out using the systems model approach to learning as outlined in the Child Practice Review process provided by "*Protecting Children in Wales Guidance for Arranging Multiagency Practice Reviews"* (Welsh Government 2012).

The overall purpose of the SCR model was to consider what happened in this case and explore why services were delivered as they were. Also, to consider how practice can be improved through changes to the system to improve outcomes for children. A Terms of Reference was developed to identify the key lines of enquiry for the review.

2.1. Key Lines of enquiry

- Determine whether decisions and actions in the case comply with the policy and procedures of the named services and the RBSCP
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies
- Examine involvement of other significant family members in the life of the child, and family support provided to the subject child.
- Examine the way in which professionals and agencies work together to safeguard local children and identify and gaps within systems and processes.
- Identify any actions required by RBSCP to promote practice which will improve outcomes for children.

Serious Case Review – Undertaken when a child dies, or is seriously harmed, as a result of abuse or neglect, a serious case review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children.

- Consider the assessments used for managing chronic neglect and examine how practitioners worked with mother to identify her capacity to change
- Examine the effectiveness of the local safeguarding children arrangements including decision making around Public Law Orders (PLO) processes and arrangements for managing difference of opinion.
- Consider the effectiveness of the multiagency response to provide protection and support once it was known that Olivia was sexually active.
- Examine the assessment and rationale for “family arrangement” placements as opposed to having a Regulation 24 placement.
- Consider the effectiveness of any Child Sexual Exploitation campaign or information provision available to young people and families in Rochdale.

The process for this SCR involved a Review Panel of representatives made up of senior managers and safeguarding leads who were from the organisations involved in providing services for the child and family. The role of the review panel was to provide relevant information and analysis of their organisation’s involvement in order to capture service/practice issues and to agree the key learning themes and actions required for multiagency practice improvement.

A composite timeline which included all agency interactions between 09/07/18 till 11/01/19 was scrutinised by the Independent Reviewer, Review Panel members and front-line practitioners at the Practitioner Learning Event. The Practitioner Event was attended by 25 front line practitioners who knew Olivia and were able to reflect and consider the key themes of learning highlighted in this review.

The learning from this review will be reflected throughout the report in a series of **“Practice Learning”** boxes which are intended to reinforce and promote areas of safeguarding practice to frontline professionals. At the end of the report there will be a number of **“Good Practice”** areas identified which reflect where professionals went above and beyond the call of duty. There will be a number of **“Practice Issues”** identified which are practice areas within and between the agencies which require some focus and improvement at individual practice and agency level. There are also, a number of **“Progress”** boxes which identify areas of practice already addressed by the local area following the onset of this review.

There are 5 **Recommendations** for the consideration of RBSCP and it is recognised that RBSCP have the authority to act (or not) on the recommendations as they feel appropriate in the best interests of children in their local area.

Public Law Order (PLO) - When a local authority makes an application for an order to safeguard the welfare of a child, the cases are usually referred to as public law cases

Family arrangement - This is a relationship which involves close family or those who live in the same household and treat each other as family. A personal, non-commercial arrangement exists where no money changes hands, or any money changing hands is given outside of a commercial arrangement.

Regulation 24 placement -This regulation allows Local Authorities to place children and young people with family members or connected carers subject to an assessment for immediate placement for a period of up to 16 weeks

Child and family focus and involvement in the reviewing process is seen as being key to understanding the nature of services provided to the individual family. Their input can provide an understanding of how helpful practitioners and services were perceived by the family members on a day to day basis.

2.2. Olivia reflections on what was happening during the timeline.

Olivia enthusiastically engaged with the review process and met with the Independent Reviewer with the support of her key social workers. The Independent Reviewer was very grateful for Olivia's contribution to the review and noted the "voice of the child" in the brief statements provided below:

- Olivia felt that professionals need to ask more questions and find out what is going on.
- *"When you are in a situation like this you feel like everyone knows what is happening to you and you expect to be asked about stuff".*
- Olivia felt people who had worked with the family over the years looked down on her mother and this was felt not to be acceptable. She felt this was *"heartless"* and had not helped.
- Olivia said that she *"just wanted someone to listen to her and support her".*
- School had been the biggest help. Olivia said that *"they believed in me" "but I could not tell them what was happening at the time so I stopped going".*
- Of the time spent with the male perpetrator Olivia said that *"at first, I thought I was in love with him, but later became afraid of him."*
- Olivia had been aware that professionals were trying to find her but the male perpetrator was keeping her away from everyone.
- When I met a professional, I would say *"I'm fine" "but my world was crashing down".*
- Asked how she felt during the time period. Olivia said *"I felt tired and stressed out most of the time". "I was looking after myself and trying to help mum". "I couldn't tell her everything I was too scared".*
- Reflecting on the help that Olivia is getting now she said *"My Sunrise worker is amazing she is helping me to become a better person".*

2.3. Mothers perspective

Although mother and the Independent Reviewer had not been able to meet personally due to COVID 19, they did have a useful telephone conversation about the time period included in this review. Mother made a number of helpful observations as follows:

- Mother told the Independent Reviewer that *"at the time I was in a very bad place" "I was in denial and scared".*
- School tried to get Olivia back to school by *"nagging at me with texts"* but *"what I needed was practical support".* On further discussion mother suggested that it would have helped if someone had collected Olivia from home on a daily basis to make sure she was attending school.
- Asked where she was when Early Help Practitioners, School Welfare and Social Workers were coming to the house and knocking on the door. Mother said *"I felt very anxious and just stayed hidden in my bedroom".*

- When asked about how services helped her, she said *"I felt there was no one there to support me". "I felt that professionals should just stop messing about and bring the whole thing to a head"* which they eventually did.
- Mother said she felt that the police should have kept her more informed about MP.
- Asked what would have helped her at the time? *"I needed someone to come in and do it* (parenting tasks) *for me"* until I was better.
- Mother now has a Sunrise Worker who she says she *"meets for a coffee and a friendly chat"* she said she feels *"this is helping me more than any of the services I have received before".*

2.4. The Reviewer had access to a number of documents as follows:

- Initial individual agency rapid response timeline of significant events/analysis.
- Child Safeguarding Practice Review Referral
- Rapid review recommendation and chair's decision
- Record of Strategy Discussion following arrest of the male perpetrator.
- Composite timeline of significant events/analysis
- Minutes of Initial Child Protection Conference

Research evidence and national statutory guidance was considered and used throughout this review.

3. Family composition and context at time of event.

Olivia	White British. Girl aged 14 years with Attention Deficit Hyperactivity Disorder (ADHD) and history of asthma, anxiety, low self-esteem and self-harm. Chronic poor school attendance and was recognised as a Young Carer with a long history of poor parental supervision and neglect.
Mother	White British. Female aged 45 years. Unemployed. Concerns about drug use over several years. Suffered from anxiety and was avoidant of professional contact. Past history of tragic unresolved personal bereavement and domestic abuse. Poor parenting felt to be intrinsically linked to mental health issues.
Half brother	White British age 29 years. Living with a partner.
Half brother	White British age 25 years. Notified police of possible sexual abuse of Olivia to try to protect her.
Half brother	White British age 20 years. Not in contact during review period.
Father	White British. Male aged 37 years. Living in the care system following a criminal violent assault leading to serious brain damage. Olivia had very little contact with him.
Male Perpetrator (MP) This adult male is known to have sexually	White British. Male aged 34 years. Unemployed. Served two prison sentences over ten years for theft and domestic abuse offences. Twenty-three domestic abuse events with ex-partner with whom he has a child. He was on probation for a variety of crimes including violent assault, theft and burglary. He had been summoned to court for breach of probation order but failed to attend court and became unlawfully at large for 6

exploited and abused Olivia	months prior to being arrested during which time he was sexually abusing Olivia.
Family Friend	White British. Age around 50. Described as having learning difficulties and mental health problems. Lived a few doors away from Olivia's home address. Olivia stayed there on and off as did MP. Family friend did try to protect Olivia by contacting emergency services.
Environment	Housing estate on the outskirts of town, known as an area of deprivation and poverty. The home address was a privately rented property which was in disrepair with broken windows and door. Rubbish was present in the garden.

4. Circumstances and significant events – 09/07/18 till 11/01/19

The complete timeline covered 24 pages with 147 separate entries over the 6-month period.

4.1. Historical information which predates the timeframe

Olivia had been known to Children's Social Care (CSC) since birth following concerns of neglect involving Olivia's half siblings. Poor parental supervision, domestic abuse and parental substance abuse had been lifelong features in the child's life resulting in her being the subject of Child Protection Plans for Neglect at various stages of her life.

The most recent Child Protection Plan prior to the period of this review had been in 2015 when Olivia was age 11 which lasted until 2016. It was found that although mother did not fully engage with professionals and the child protection process, she did manage to address some of the concerns identified by professionals and she was able to demonstrate an ability to parent and care for Olivia. However, once the Child Protection Plan was stepped down to a Child in Need Plan and then to a Common Assessment Framework (CAF) which was soon closed because mother failed to attend four out of five CAF meetings.

Olivia was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in 2015. Routine cardiac screening took place prior to being prescribed medication with no abnormalises or risks being identified. Olivia was commenced on medication but "was not brought" to essential hospital appointments to monitor her condition which resulted in the management of the child's ADHD not being as effective as it should have been. Also, during this time there is evidence recorded that Olivia made a number of disclosures of deliberate self-harm.

Child Protection Plan – should assess the likelihood of the child suffering **harm** and look at ways that the child as be protected; decide upon short and long term aims to reduce the likelihood of harm to the child and to protect the child's welfare.

Child in Need – a child will be considered in need if: they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority.

Common Assessment Framework – is the process to identify children who have additional needs, assess needs and strengths and to provide them with a co-ordinated, multi-agency support plan to meet those needs.

Attention Deficit Hyperactivity Disorder (ADHD) is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness.

"was not brought"- previously known as **did not attend** (health appointments) and relates to a child who is dependent on an adult carer to take them to an essential health check

School had tried working with Olivia and mother around attending school and essential hospital appointments without success. School attendance was a continual problem with attendance standing at 51% in 2018 and 49% the year before. Mother had previously been fined for Olivia's poor school attendance and education welfare were in the process of pursing this once more as the case moved into the period identified for this review.

4.2. Significant Events during the timeframe in chronological order.

July 2018 – Event (1) – Olivia was taken to the local hospital Accident and Emergency Department (A&E) in the early hours of the morning via ambulance. The ambulance had been called by "grandma" (later found to be family friend) because she had thought the child was in labour. When the ambulance arrived, the child was found in bed naked from the waist down and was complaining of severe lower abdominal pain. Grandma and "brother" (later found to be the male perpetrator) were reported to be clearly stressed and walking in and out of the bedroom.

Olivia was found not to be in labour and A&E concluded the pain was related to sexual intercourse 4 weeks ago with a peer and Olivia was concerned about pregnancy having had a missed period. A pregnancy test was carried out and found to be negative and the child was referred to a Gynaecologist for further consultation. There was a request for mother to attend A&E prior to any intimate examination but Olivia left A&E with her "brother" (male perpetrator (MP) without being seen.

The A&E staff nurse contacted EHASH (Early Help and Safeguarding Hub) due to Olivia having a Child Protection – Information Sharing (CPIS) flag on their electronic record system for a previous child protection status. The decision of EHASH was for further enquires to be made via Early Help to gather information to determine the level of child and family support required.

July 2018 – Event (2) – Olivia randomly went into school (11 days later) on the day that school was about to break up for the summer break. Olivia told her learning mentor that she was feeling very depressed and was having tummy ache. Olivia said that she was worried that her mother had suffered a "mental breakdown" and the child had been too afraid to leave her to go to school. The learning mentor contacted the child's GP for an appointment which was later attended by the child.

School informed Early Help of the disclosure made by Olivia and their action taken to secure a GP appointment. The Early Help worker later contacted the GP for information about Olivia and was informed that Olivia had disclosed consensual sexual activity with two different 15-year-old boys.

Early Help and Safeguarding Hub (EHASH) – is Rochdale's main front door or main point of access to children's social care. All concerns regarding a child or young person suffering or at risk of significant harm should be reported

Child Protection – Information Sharing (CP-IS) – is an automated system for when a child is known to social services and is a Looked After Child or on a Child Protection Plan basic information about that plan is shared securely with the NHS. If that child attends an NHS unscheduled care setting, such as an emergency department or a minor injury unit social care are automatically alerted to ensure they are aware as part of the child's ongoing assessment and protection.

Early Help Service – It assesses the situation of the child or young person and their family and helps to identify the needs of both the children and the adults in the family

The GP referred the child to sexual health services for sexual health screening, advice and support.

A Child Protection referral was made to CSC from Early Help regarding Olivia's unmet health needs, poor school attendance and non-engagement by mother. The referral was declined pending further information gathering around family living arrangements.

August 2018 – Event (3) An Early Help worker who knew Olivia well requested a case file audit which was undertaken by the Head of Service. Based on the findings of the audit a referral to EHASH was accepted and Olivia was allocated to a Social Worker to undertake a child and family assessment.

September 2018 – Event (4) The Social Worker and Early Help worker attempted a joint home visit to engage with Olivia and her mother. Two males were seen coming in and out of the house before driving off together which looked suspicious. After the males left the area the workers knocked on the door several times believing there was someone at home but no one came to the door. The Social Worker and Early Help Worker were concerned that Olivia was involved in the suspicious activity of the visiting males in some way.

October 2018 – Event (5) At a further home visit, damage was seen to the family home living room window which appeared to be made by ball bearing pellets. This was reported and followed up by the Police with an outcome that the damage had been done by an unknown person with no concerns identified relating to Olivia. The Child and Family Assessment was concluded at this point with a recommendation to progress to a section 47 (child protection). Mother continued to be uncontactable and Olivia was still not attending school.

November 2018 – Initial Child Protection Conference (ICPC) with an outcome agreed for a Child Protection Plan under category of Neglect. Mother and Olivia did not attend the conference. The IRO (Independent Reviewing Officer) recognised that Olivia had been neglected for most of the child's school life and strongly recommended that CSC urgently consider taking legal advice in respect of Olivia circumstances with a view to initiating pre-legal and legal processes.

November 2018 – Event (6) – At an early evening visit to the home address the social worker was concerned to see Olivia leaving home and walking along the street with an unknown older male (MP). The pair entered the family friends' home (situated a few doors away) and soon after the pair returned home again. The social worker contacted the police to gain entry to Olivia's home for a "safe and well check" because despite multiple attempts Olivia had not been seen for 4 weeks.

Child Protection (section 47) – Statutory requirement under the Children Act of 1989 for enquiry and assessment to be led by a qualified social worker from Children's Social Care, who will be responsible for its coordination and completion. The social worker must consult with other agencies involved with the child and family to obtain a fuller picture of the circumstances of all children in the household, identifying parenting strengths and any risk factors

Independent Reviewing Officer (IRO) – is the person who ensures that children looked after or subject of a child protection plan by the Local Authority have regular reviews to consider the care plan and placement

Police "safe and well check" – also referred to as welfare checks on people who are vulnerable, the police are required to locate people at risk of harm and seek to manage any safeguarding risks.

On entering the property, the police found the unidentified male (MP) hiding upstairs, he refused to give any personal details and was anti-police. Mother told the police and social worker that it was she who was in a relationship with the unidentified male (MP) and not Olivia. Olivia confirmed mothers' story and privately provided the name of the unidentified male giving a false name.

December 2018 – Legal Gateway meeting – the decision was taken that the threshold for PLO (Public Law Order) had been met however, due to concerns about maintaining a placement for Olivia due to the level of loyalty she held for her mother, it was agreed that Olivia should remain on a Child Protection Plan and the case reviewed in 4 weeks.

December 2018 – Event (7) – Allegations were made to the police by a male friend of MP (correct name for MP provided at this point) who stated that he had been assaulted 2 days earlier by MP after he had been drinking and smoking weed. Olivia had been present and concerns were reported about her poor level of hygiene. It was alleged that Olivia had been pushed around by MP and the male friend had concerns that MP maybe controlling Olivia in some way.

Unfortunately, due to high demand on local policing resources the incident was delayed for 4 days following which it took a further 8 days for an officer to locate Olivia a total delay of 12 days. The officer closed the log because Olivia was seen to be safe and well and after speaking with child it appeared to have been a malicious call.

January 2019 – Event (8) – An allegation that Olivia was in a sexual relationship with a 34-year-old male was made to the police by Olivia's half-brother. The brother stated that he had been told by his sisters' friend and that his mother did not know about it. The previous event in December 2018 was reviewed by the police inspector on duty who reconsidered that the previous allegation made by a third party had been correct and plans were put in place for immediate action and arrest of MP regardless as to whether Olivia supported the allegations or not.

January 2019 – Event (9) – The police attended Olivia home in the early hours of the morning and found MP hiding behind the wardrobe upstairs. He was arrested on suspicion of sexual activity with a child. Mother continued to maintain that it was she who was in a relation with MP. Whilst in the property the police observed that Olivia's bedroom had no bed and was "full of junk" and there was no room for anyone to sleep in there. A referral was made to EHASH emergency duty team.

Legal Gateway Meeting – The purpose of this meeting is to obtain advice as to whether the 'threshold criteria' for a care order under section 31 Children Act 1989 (Child care proceedings) have been met. The legal planning meeting is usually attended by the child's social worker, manager and a legal adviser.

Public Law Order (PLO) – When a local authority makes an application for an order to safeguard the welfare of a child.

Emergency Duty Team – provides an emergency social work service for urgent situations which arise out of normal office hours and which cannot be left with an appropriate degree of safety until the next normal working day.

Probation Order – an order imposed by a magistrate or judge under which an offender is sentenced to probation rather than imprisonment. Offenders on probation must keep to the requirements stated by their Court Order or Release Licence.

Sunrise (CSE) Team – are a multiagency team who works on the front line in Rochdale, Heywood, Middleton and the Pennines, reaching out to young people at risk of child sexual exploitation in the community.

January 2019 – MP was charged with the offence of Breach of Probation Order and was refused bail and remained in custody until the court hearing 2 days later. MP was then police bailed pending enquiries for sexual activity with a child and bailed to a separate address with conditions for him not to see or to make contact Olivia. The case was then transferred by police CID to a specialist police officer at Sunrise (CSE) Team to progress the investigation.

January 2019 – Event (10) – A 999 emergency call by the family friend to the police 4 days following MPs court appearance. The family friend was very upset to have found Olivia together with MP at her home. The police quickly arrived to the house and forced entry where MP was arrested on suspicion of Rape. Police used their police powers to remove Olivia from the address and to place Olivia in a place of safety with a family member and mother was arrested on suspicion of child neglect.

5. Analysis of practice and organisational learning

5.1. There were three main learning themes which emerged during the reviewing process as follows:

- **Recognising child sexual abuse /exploitation (CSE).**
- **Impact of adverse childhood experiences (ACEs).**
- **Adolescent Neglect and Safeguarding.**

6. Theme 1 – Recognising Child Sexual Abuse / Exploitation (CSE)

The catalyst for this SCR was that a 14-year-old girl was seriously sexually exploited and abused within a community setting. Agencies were working with the child and family at the time around neglect issues which involved poor school attendance and a lack of engagement with support services.

6.1. National information on CSE

Barnardo's have identified that a common pattern in the sexual exploitation of adolescent girls is the presence of an older boyfriend. In more than three-quarters (77%) of cases where young people were at risk of CSE and experiencing intimate partner violence, the Barnardo's case holder recorded that the risk was increased because of the age of the perpetrator.

Whilst the presence of an older "boyfriend" is most commonly seen in CSE other types of CSE may involve peer on peer, organised networks and/or adults in key positions of responsibility such as teachers, sport coaches and religious leaders.

Police Protection Power (PPP) – A Police Constable has the legal right to remove a child from accommodation or prevent removal, where they have reasonable cause to believe the child would otherwise be likely to suffer significant harm.

Barnardo's – is a children's charity that works to protect and support the UK's most vulnerable children and young people.

All forms of CSE have an element of “grooming”. Grooming is when someone builds an emotional connection with a child to gain their trust for the purpose of sexual abuse, sexual exploitation, or trafficking. Child and young people can be groomed on-line or face-to-face, by a stranger or by someone they know. (NSPCC website)

Statutory guidance for practitioners has defined CSE as *a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact; it can also occur through the use of technology*. (DfE 2017)

NSPCC Messages from research on identifying and responding to disclosure of child sexual abuse (Pam Miller and Helen Baker – September 2019) demonstrates that children’s disclosure of sexual abuse varies in the mode of communication, intent spontaneity and amount of detail that is included. Verbal disclosure rates are low at the time of abuse and children say that they are trying to disclose their abuse when they show signs or act in ways that they hope adults will notice and react to.

Researchers have also found that professionals often failed to pick up signs of CSE and that adolescents were more likely to disclose to peers rather than professionals (Allnock and Miller 2013). Many disclosures are either not recognised or understood, or they are dismissed, played down or ignored, which means that no action is taken to protect the child and the child’s faith in the professional to act on their behalf is suppressed.

6.2. How children and young people may disclose CSE:

- **Direct disclosure –** (may be accidental or prompted) comes often at the point when the child feels safe from the perpetrator; or where they fear the abuse more than the reprisals; or to protect someone else.
- **Partial verbal disclosure –** is when the child tells a part of their story expecting the professional to fill in the gaps or they may say the abuse is happening to someone else and not them expecting the professional to guess it is them.
- **Nonverbal / behavioural disclosure** – may be a drawing, letter, change in behaviour including becoming angry or withdrawn; secretive and dismissive; developing unresolved health issues such as panic attacks or abdominal pain.
- **Assisted disclosure** – when a child is helped to disclose by a close friend or trusted adult.

The Independent Reviewer was able to ask Olivia if at any time she had been trying to disclose to professionals what was happening. Olivia responded – *“yes all the time”* and confirmed that Event (1) had been a cry for help. Olivia had been surprised that professionals did not ask her more questions about the situation in A&E. However, this should be balanced with the fact that the child left the department before a full examination of the situation could be carried out.

NSPCC recommend that professionals need to keep an open mind that any child or young person could be attempting to disclose sexual abuse/ CSE. Teachers and health care professionals are the people which children and young people will most commonly disclose to, but the process of disclosure can be helped or hindered by the way in which professionals engage with the child or young person about whom the concern exist. Children and young people want to be asked how they are doing and what is going on in their lives so there is a basis for the development of a trusting relationship and open dialogue.

6.3. Local information on CSE

In 2012, Rochdale had a high profile CSE case involving underage teenage girls who were sexually abused by a number of men who were later convicted of sex trafficking and other offences involving rape and sexual activity with a child.

The legacy of this case was the emergence of the Sunrise Complex Safeguarding Team established in 2013 which tackles CSE and related harm across the borough of Rochdale. From 2019 the team have further expanded to Complex Safeguarding including CSE and Child Criminal Exploitation. The team includes experienced professionals from the police, children social care and health. They provide a safe and confidential environment where young people can go for help, advice and support. Children are offered a range of therapeutic interventions including one-to-one counselling, group-work and drop-in support.

Referrals for Sunrise Complex Safeguarding Team are received through EHASH. The Sunrise Complex Safeguarding Team can offer direct advice and support to professionals and family members with concerns. Sunrise has a role to provide CSE training for professionals and work in schools to deliver preventative CSE education programmes. There is a good on-line presence for professionals and young people to find further information.

Project Phoenix was launched in November 2015 across Greater Manchester to raise awareness of CSE and they held a number of training events for professionals and parents. They developed a resource "It's not OK" to help to identify CSE which is available on Rochdale Borough Safeguarding Child Partnership (RBSCP) website. Useful resources on the RBSCP website include Newsletters, video clips, links to other websites for support and a CSE measurement tool which was developed in 2015. Multiagency CSE training is available via the RBSCP website.

6.4. Historical information on Olivia and relevance to CSE

Historically, Olivia had been subject to chronic neglect and one of the main features had been poor supervision. In 2011, when Olivia was age 7, there had been a strategy meeting over concerns of on-going neglect and an anonymous referral made to CSC about concerns of sexual abuse which were unsubstantiated. A further strategy meeting took place in 2014 over concerns that Olivia (age 10) was going out unsupervised and had been sexually inappropriately touched by a peer.

It is not apparent that this historical allegation of child sexual abuse was ever utilised in the assessment of new referrals for Olivia in terms of her being missing or being seen with an older male.

The impact of any form of sexual abuse can have a long-term negative impact on mental health. A past history of sexual abuse can increase the vulnerability of a child or young person, which can make them more susceptible to the grooming process and increases their risk of potential sexual abuse and/or other forms of exploitation. (NSPCC UK).

Practice Learning
EHASH should ensure that any current or historical concerns about sexual abuse are flagged/highlighted within the child's record to prompt social workers to recognise the potential increased risk and vulnerability in relation to the child's future risk of sexual abuse and other forms of exploitation in the future.

6.5. The context of CSE found in this review

At the beginning of the Olivia's timeline there was an event (1) of a sexual nature which could be described as "odd". A full forensic review of the facts within the event could have resulted in agencies considering sexual abuse / exploitation earlier had the details of the event been fully checked out and considered in more depth at the time.

The features of the event (1) which could have alerted professionals to consider possible sexual abuse include:

- The ambulance being called to an address in the middle of the night for a 14-year-old child in labour. *The child did not look pregnant so what was that about?*
- The caller had said she was "grandma" but was actually a family friend.
- The 14-year-old child presenting to ambulance staff lying on a bed in a half-naked state. *Most 14-year old girls would have covered up why not in the case? What was the child indicating?*
- The address at which the event took place was that of a family friend's which was just down the road from the child's home address. *Why was the child staying at that address and not at home?*
- The ambulance staff raised concern about "grandma's" ability to care for a child. *Why was the child staying with grandma? Details of grandma? What was the lady's capacity to care for Olivia?*
- The ambulance staff raised that the grandma and "brother", later found to be the male perpetrator (MP), were both acting very stressed and kept walking in and out of the room. *What was the odd behaviour about? Details of brother?*
- The nature of the abdominal pain said to be as a result of sex with 2 peers 4 weeks earlier and concern about pregnancy. *Concerning history for a 14-year-old girl. Is it likely that pain from sexual intercourse with a peer on 2 separate occasions would cause pain 4 weeks after the event?*
- The child leaving A&E with the so called "brother" without seeing the Gynaecologist, having apparently been in excruciating abdominal pain earlier. *This should act as an*

alert to professionals– often patients who do not wait to be seen have something to hide.

- The child's past history of neglect and sexual abuse. *Increased risk of vulnerability.*
- The child missing from school. *Children who go missing (from education) is a key indicator for CSE*
- A&E referred to CSC that the child had been to their department and had a flag for a previous child protection plan via the CPIS system.

An appropriate child safeguarding referral was made by both ambulance service and A&E to CSC at EHASH which resulted in the case being allocated to the Early Help service to forensically gather information about the child's circumstances to identify what level of support was required to support the child and family.

There were a number of suspicious factors within the context of this event which should have alerted professionals to fully address the all details of the event. Checking out names and addresses of the individuals present at the event or attending A&E is of particular importance to enable police to conduct full background checks of individuals for cases which may then become child protection.

A&E had recorded the full details of the child and the first name of the "brother" and his telephone number. A&E staff had enquired about mother as the person with parental responsibility and were informed that mother was aware of the child's attendance. A&E staff requested that mother should attend the department to support the child during the Gynaecologist consultation which is best practice. However, Olivia and brother soon left after this point.

Early Help and school did initially start to piece the detail together but then unfortunately, the mother and child were uncontactable for several days and as the case "drifted" the impetus around challenging the initial event appeared to be lost.

A more multiagency focus following the event may have been beneficial in terms of seeing beyond the child's behaviour and considering the nature of the concerns at the time. A discussion with the family friend at the address the child was collected by the ambulance team may have provided earlier information about Olivia possibly being sexually active with the unknown male (MP).

Whilst agencies were concerned about Olivia, they did not take the opportunity to come together to consider the meaning of the event. Olivia confirmed to the Independent Reviewer that she was demonstrating behavioural disclosure to alert professionals that she needed help. The event (1) provided actual evidence of safeguarding concerns and provided an opportunity for professionals to assertively pursue the details of the event to fully assess what was happening. ***(Local safeguarding arrangements to be discussed later).***

Practice Learning
Events/incidents are very useful because they provide a window of opportunity to allow agencies to fully unpick a snap shot of a child's life. Verifying the detail of an event into a factual account including who, what, when, where and how can result in an opening up of the story to enable professionals to better assess and understand what is happening and what may be being hidden.

6.6. Olivia's perspective on practitioner involvement.

On speaking with Olivia about the event (1) the Independent Reviewer has been able to confirm that Olivia was trying to alert professionals that she needed help. She was surprised that staff at the hospital A&E did not ask her more probing questions about what was happening to her. She felt A&E staff would be able to tell that something untoward was going on. Olivia said that MP made her leave the department before being seen, she felt this was because he did not want her tell anyone about what was going on.

Practice Learning
Young people who are being sexually exploited need professionals to see them alone and to be more professionally curious by asking them more probing questions to try to find out what is happening to them. Record keeping should include a clear account of what the child was saying and include all relevant demographic and presenting detail including who the person was attending with the child. Persons who refuse to provide basic personal information should be viewed as suspicious and raise alarm.

There were a number of other events which could have triggered professionals to be professionally curious and consider possible CSE and or other safeguarding concerns as follows:

- Olivia randomly going into school after a long period of not attending to report tummy pain and depression just before school holidays.
- Unknown males seen coming in and out of the house acting suspiciously.
- Police found unknown male (MP) hiding upstairs and later confirmed that Olivia had given them a false name.
- Olivia with an unknown older male walking down the street to the family friends address and when the social worker tried to engage Olivia at the address the couple left the property and ran down the street together.
- Unknown male stating he was in a relationship with mother when he was always seen with Olivia.
- Story that they were together because unknown male babysitting Olivia whilst mother at bingo. Especially taken into context with the history of neglect and previously being left unsupervised.
- Event (7) of an allegation reported to police about concerns for Olivia's level of hygiene and being linked with MP with his real name being given to the police for the first time. Olivia had been drinking and was seen being pushed around by MP whilst he was smoking weed and being violent towards his friend.
- Event (8) allegation made by Olivia's half-brother that Olivia was being sexually active with MP. This was accepted and police intervention rapidly took place.

During the 6-month timeline it is clear that a number of the agencies did consider CSE independently at different points but the information each agency held did not come together sufficiently to change the way the agencies worked together to try to assess her CSE risk and support to Olivia. The Core Group of staff working with Olivia appear to have remained focused on managing child neglect in accordance with the Child Protection Plan.

As previously mentioned, Rochdale have a bespoke service called Sunrise Complex Safeguarding Team, for children and young people in situations where CSE may be a potential risk to the child and it is surprising that the agencies who were considering CSE did not consult with Sunrise sooner. In fact, Sunrise were not alerted until after the perpetrator was arrested. Sunrise Complex Safeguarding Team members who attended the Practitioner Leaning Event stated they were disappointed not to have been contacted sooner.

Practice Learning It is important that professionals have an early consultation with the Sunrise Complex Safeguarding Team in situations where CSE is suspected – even when the assessed level of risk is low or concerns about CSE are unsubstantiated. Referrals to Sunrise are made via EHASH.

Olivia was reporting to health professionals about her concerns around pregnancy and unresolved abdominal pain for several months. There was a medical focus on possible sexually transmitted diseases which resulted in the GP referring Olivia to the Sexual Health Service for screening and wider support.

Olivia attended the first Sexual Health Service appointment with an aunty and was seen alone for sexual transmitted disease testing which were negative. Age appropriate relationships were disclosed during the consultation and names and age of sexual partners recorded. The service young person proforma was completed and updated at each subsequent appointment in line with best practice. Following the initial consultation Olivia was referred on to the Sexual Health Outreach Team (SHOT) to commence an education programme.

Olivia did not attend 3 of the available appointments mainly because the appointments were offered in school and Olivia was not attending school. The SHOT worker visited at home to try to see Olivia and to offer a new appointment. Olivia engaged in 4 further appointments. At 2 appointments she gave new partner information which were age appropriate and at 1 appointment Olivia disclosed she had recently split up with another partner because of having a chaotic relationship with them. Again, details were recorded and seen as being age appropriate. At 1 other appointment Olivia attended with her mother for an education session.

Despite health professionals being aware that Olivia was subject of a Child Protection Plan and Olivia disclosing multiple partners, CSE did not appear to be on any of the health professionals' horizons as much as it could have done. Olivia visited the GP on 3 occasions; Sexual Health Service appointments on 5 occasions; A&E on 1 occasion. Most presentations were for sexual activity linked complaints / issues.

Children and young people who attend services attend because they are seeking help and support. As previously stated, children who are being sexually abused/exploited are often too afraid to provide a direct verbal disclosure and will therefore, provide an alternative story to cover up the truth whilst giving out the message that they need help through partial disclosure or behavioural disclosure. It therefore takes skill and experience to be professionally curious and to ask the right questions and to build trust to allow the child to disclose safely.

Practice Learning
Professionals should be professionally curious and alert to the signs of possible CSE in situations when children and young people present with medical complaints linked to sexual activities. CSE should remain on any list of differential diagnosis until there is evidence that CSE can be excluded.

It was not until Olivia was sure that MP was locked away in prison that Olivia felt safe enough to fully disclose what had happened to her. This is a common trend in CSE and other cases of child sexual abuse.

6.7. The male perpetrator (MP) as an offender.

The male perpetrator was a 34 years old local man, thought to be of no fixed abode but actually lodging with the family friend and was unlawfully at large throughout the majority of the timeline. The circumstances had been that MP was in breach of his probation order and had failed to attend court in respect of this resulting in a warrant being issued for his arrest which was passed on to the police by the probation service.

This is not an unusual event for probation and the police and MP would have been risk assessed along other known offenders who required arrest. MP had committed a number of relatively low-level crimes including a violent assault, none of which were linked to children or sexual crimes.

Practice Learning
Nationally, it is recognised that police resources are not enough to arrest every known offender in a timely way. Whilst risk assessments assist the police in arresting the most dangerous criminals quickly there are occasions when offenders are at large for longer periods than the police and society would wish and this is a Public Protection issue.

Progress
Police locally now have a process in place whereby weekly details of any new warrants carried by the enforcement team are sent through to the Warrants Officer for information and assessment. This ensures that the Warrant Officer is sighted on any warrants that may pertain to known divisional offenders and as such can be included in activity for enforcement going forward. This is a new process and under review, this should ensure a safety net for Breach of court orders or non-payment of fine issues that relate to risk cohorts on the district.

It is possible that MP was “sofa-surfing” and moved in on the family friend who was a vulnerable lady by way of her learning disability and mental health issues.
This is an example of ‘Cuckooing’ which is recognised as the practice of taking over a person’s home to use their property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds. MP was said to be a lodger at the address but in reality, was probably an uninvited guest. MP was well known to the neighbourhood and people were afraid of him

It would have been good practice for one of the professionals involved to have visited the family friend at home to clarify what was happening at her address on the night of the initial event (1). It was possible that the family friend may have told the professional the name of MP and shared her concerns about Olivia being involved with MP. There would have been an opportunity to identify if the lady had her own vulnerabilities in terms of possible exploitation and to consider the need for a referral to adult social care for support as a possible adult at risk.

6.8. Hidden Men

It was apparent that MP was trying to remain anonymous by getting others to provide false information about him and trying to hide away from professionals. Despite these efforts he was seen with Olivia by a number of professionals. Olivia’s mother was aware of their relationship but provided false information to police and social care that it was she who was in a relationship with MP and not Olivia. Mother clarified to the Independent Reviewer that she too was afraid of MP and had lied to protect herself.

Improving practice around hidden men (NSPCC 2015) reflects that professionals rely too much on mothers to provide essential information and do not often talk enough to other adults in the child’s life which can result in them missing crucial information and failing to spot inconsistencies in the mother’s account.

Practice Learning
NSPCC learning from other serious case reviews suggests that professionals should “identify and carry out checks on any new adults who have significant contact with vulnerable children. Always clarify who the members of a household are each time you visit a family”.

6.9. Olivia’s perspective of the grooming process.

Olivia told the Independent Reviewer that she was initially “in love” with MP. The grooming process involved MP first being kind to Olivia and he spent a lot of time listening to her thoughts and feelings which made her feel special. This moved on to MP sharing his own life story with Olivia which made her feel grown up and trusted. Their relationship then moved to being sexual after which MP began to control Olivia and he would actively keep her away from school and from the professionals trying to contact her. Olivia later became afraid of MP and what she felt he was capable of doing.

Olivia's story is typical of other girls who have been groomed by an older male. The initial phase of CSE is the grooming process and according to the NSPCC (2018), grooming is currently defined as: "When someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking". This is followed by the perpetrator isolating the child from friends and family. Once the sexual abuse is occurring, offenders commonly use secrecy and blame to maintain the child's continued participation and silence.

6.10. Mothers perspective of what happened to Olivia.

Mother told the Independent Reviewer that she was not fully aware of everything that was happening at the time. Olivia did tell her mother that she was in love with MP because he listened to her. Mother, who already knew MP as a friend of her son, became afraid of MP which led her to lie about being in a relationship with him. She had been uncontactable because she was in a "bad place" with her mental health and was using drugs to try to get herself well again. She was spending most of her time in her bedroom at home hiding from everyone.

Professionals who knew mother commented that the level of avoidance exhibited by mother was not new behaviour because this was how she had behaved in the past when agencies were trying to get involved to help the family.

During the review period mother was not in a good enough physical or psychological state to parent her daughter, in fact Olivia was caring for her mother in the midst of her own CSE situation. Olivia tried to raise the alarm about mothers deteriorating state of health during event (2) when Olivia attended school to speak to her learning mentor stating that she thought her mother was having a breakdown.

Practice Learning
When a family for whom there are concerns become uncontactable or uncooperative with agencies, a **Think Family** focused multiagency strategy meeting should be convened to consider the separate needs of the children and vulnerable adults going forward. To aid this process adult mental health, GP, and relevant others such as adult social care and drug services should be included. ***Remember when adults are vulnerable – children are vulnerable.***

6.11. Arrest and prosecution

In September 2018 the police were made aware during a strategy meeting (which progressed to the level of Child in Need) that Olivia had admitted to sexual activity with 2 different boys who were of the same age (14 years). The police agreed to check their systems against the named boys and provide feedback to CSC which they did and there were no concerns in relation to the boys. At this stage there was no information about Olivia being involved with an older male.

The police subsequently attended an Initial Child Protection Case Conference where the outcome concluded neglect. Two weeks later the Social Worker requested a Police visit for a

safe and well check because there were concerns that Olivia had not been seen 4 weeks despite numerous visits to the home. Olivia was in the company of an unknown older male (MP) at the time and they were going into the family friend's address where there was concerns about criminal activity at the address. The Social Worker spoke with the family friend at the address and was told that that she was concerned that "possibly something has gone on sexually between the lodger (MP) and Olivia".

The couple then ran off when the Social Worker tried to see Olivia at the address and they went back to Olivia's home where the police met the social worker and a safe and well check was conducted. MP was found hiding upstairs with the explanation that mother was in a relationship with MP not Olivia. Olivia gave a false name for MP and therefore Police were unable to identify MP as a known offender. As previously stated, children and parents who have been groomed will often provide false information to the police in order to protect themselves.

The following week a third-party report was made by a man who stated they were a friend of MP and made an allegation of assault against MP (Event 7). This was the first time MP had been named with the correct name and the friend said Olivia was MP's sister which was incorrect. The third party informed the police that he had seen Olivia drinking alcohol and she had been seen being pushed around by MP. The informant was worried that Olivia was not looking after her appearance and that MP maybe controlling her.

Due to high demand locally, there was no available police resource to deal with the incident for 4 days. The police then visited Olivia's home address on 5 occasions over 5 days until Olivia was located at home. In total from the original report to the police it took 12 days to find Olivia who was already known to be at risk of significant harm.

The findings of the visit was that Olivia appeared safe and well and had refuted what was said to have happened in event 7. The police log was closed as it appeared it had been a malicious call. CSC had not been informed of the incident as would have been expected.

Again, there was a successful attempt to cover up the abuse to protect MP. Although there were no concerns for Olivia at the time, the fact that she was on a child protection plan and there were concerns about her hygiene needs and involvement with a violent older male. On this occasion, CSC were not informed of the allegation and concerns being made which was an omission in expected practice.

Practice Learning
When a child is subject of a child protection plan all professionals need to share any new information relating to the child and family with the allocated Social Worker who will be able to make an assessment of the situation as a whole in relation to safeguarding the child.

Just 2 weeks later Olivia's half-brother contacted the police and informed that Olivia was in a relationship with a 34-year-old man and that he and his brother had intervened. This led to a review of the previous log and with now 3 separate accounts of Olivia being in a relationship

with MP led to immediate action. This demonstrated good police management oversight of the situation and led to swift action being taken.

Police called at Olivia's address where they found MP hiding behind a wardrobe. MP was arrested but Olivia and mother did not disclose any offence at this point which is not unusual with CSE related offences.

MP denied all allegations of sexual activity with a child and was therefore charged with the breach of court order which had been outstanding for 5 months and he was refused bail pending attending court appearance.

Police bail conditions were issued for the sexual activity offence and required that MP stay at a different address and was told to stay there between 11pm and 7am every day and not make any approach to Olivia. But 2 days later the police were called to the family friends address where MP was found with Olivia and he was arrested on suspicion of Rape.

Police exercised their Police Powers of Protection and following liaison with CSC and Olivia was taken to stay with family members. Mother was arrested on suspicion of child neglect following concerns that she had been implicit in the sexual exploitation.

The criminal investigation was transferred over to a specialist police officer in the Sunrise Complex Safeguarding Team. The health professional from the Sunrise Complex Safeguarding Team who attended the practitioner learning event reflected that they had not been aware of the police bail conditions at the time.

The benefit of handing the case over to the Sunrise Complex Safeguarding Team sooner would be that they have a team of specialist workers who are skilled and experienced in working and supporting children and young people who have been groomed and would have been in a better position to recognise the signs and behaviours of CSE.

7. Theme 2 – Impact of adverse childhood experiences (ACEs)

7.1. The relevance of ACE's

Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences that can have a huge impact on children and young people throughout their lives. As well as the most commonly known ACEs, there are a range of other types of childhood adversity that can have similar negative long-term effects. These include bereavement, bullying, poverty and community adversities such as living in a deprived area, neighbourhood violence etc. (Collingwood. S. 2018)

The ten widely recognised ACEs, as identified in a US study from the 1990s, are:

parents divorcing or separating
living with a parent who is depressed or suffers mental illness
living with a parent who is an addict (alcohol, drugs, or otherwise
witnessing your mother being abused or mistreated
verbal abuse/emotional abuse and humiliation
emotional neglect
physical neglect
physical abuse
sexual abuse
a family member going to jail

The impact of ACEs is that it can create harmful levels of stress (toxic stress) which can impact on healthy brain development. This can result in long-term effects on learning, behaviour and health. Evidence from ACE surveys in the US, UK and elsewhere demonstrates that ACEs can exert a significant influence throughout people's life. ACEs have been found to be associated with a range of poorer health outcomes with shorter life expectancy. The outlook on social, educational and employment outcomes decline as the number of ACEs increase. (Frederiken, L 2018).

Practice Learning
ACE's have a negative impact on child health, development and academic achievement. Front-line staff need to be ACE aware to be able to provide trauma informed support. Early action and prevention can have a profoundly positive impact upon an individual child's physical health, academic achievement and emotional wellbeing.

7.2. ACE's and links to CSE

Barnardo's have found that CSE is much more prevalent in girls than it is in boys and that historic abuse is particularly prevalent amongst young people at risk of child sexual exploitation. In other words, girls with ACEs have an increased risk of CSE.

Of the children on Barnardo's caseloads for CSE more than half (60%) of young people had experienced historic abuse. One in three (34%) young people at risk of CSE had experienced neglect in their childhood. 31% had been physically abused in the past. A quarter (24%) of the young people had experienced sexual abuse in childhood. Existing research by Barnardo's suggests that childhood abuse affects young people's self-worth and may make them more vulnerable to abuse in the future.

These facts are relevant to Olivia since she was known to have suffered the whole range of abusive factors (ACE's) as described by Barnardo's. She was also, missing from education which is a key indicator of CSE and she was seeking out professionals on her own terms in relation to having sexual activity related medical needs.

Practice Learning
Teenage girls who have suffered past ACE's are more vulnerable to becoming victims of CSE in the future. Professionals who routinely see teenage girls who are known to have ACE's and are sexually active should be asked routine questions about their relationships and consider signs of safety. Building trust by showing kindness, empathy, being professionally curious and offering additional appointments to see the child again can be very beneficial in providing a safety net for girls at risk of CSE.

6.3. ACEs and impact on Mental Health

Neuro-science have considered the links between ACE's and the effects on mental health and suggest that the more ACE's a person is exposed to the greater the risk of mental health

issues. Olivia was known to have experienced between 6 – 8 ACEs during her childhood which is a high number in terms of her risk to her future mental health.

ACE's have a direct impact on brain development during childhood, this is due to the stress hormone cortisol which is released into the brain during ACE's. Cortisol is present in humans to help us "fight, flight or freeze" in any dangerous situation. The problem arises when stress (fight or flight) becomes a constant state which allows cortisol to build up and then becomes toxic stress which makes the person over stimulated to situations leading to distress, and psychological issues such as anxiety, depression and even brain damage. (Frederiken.L.2018)

Olivia was diagnosed with ADHD in 2015 and following routine cardiac screening was prescribed medication. It is not known if this was linked to ACEs but there is a possibility that it may have been. Olivia missed out on regular reviews for her ADHD because she was not taken to essential hospital appointments ("was not brought") by her mother and therefore, the full extent of her ADHD was not clarified.

Olivia informed the Social Worker that whilst she was staying with the family friend, she was not taking her ADHD medication and she felt this was affecting her ability to sleep and increasing stress levels. The Social Worker made enquiries to the Child Mental Health Services who found that Olivia had not attended appointments in 2016 and 2017. A further appointment was made and Olivia was able to attend and medication was reissued.

Practice Learning
When a child "was not brought" (previously known as "did not attend") to essential medical review or mental health appointments a risk assessment should take place to consider medical neglect in terms of significant harm.

Olivia made reports of poor mental health to professionals on at least 6 occasions across the time period which included:

- Feeling very depressed
- Having panic attacks
- Crying through the night
- Not sleeping at night
- Told school she wanted her mental health to improve
- Feeling stressed
- Anxiety

None of these signs were fully addressed with Olivia in terms of why she was feeling this way at the time. Professionals referred the problem on which led to an appointment with the local psychological services, but when Olivia did not attend the first appointment the service wanted to close the case. School managed to intervene to gain an additional appointment.

Practice Learning
Services for children and young people should not close referrals for a one-off non-attendance. They should refer back to the referring agency to consider the risk to the child or young person in terms of the risk to the child.

Later in the timeline Olivia was referred to mental health services by the GP because of concerns that Olivia was having panic attacks and had unresolved abdominal pain. Despite the child being on a child protection plan the GP did not appear to explore the wider social issues which may have been prompting her presenting clinical medical signs. Professional curiosity is key to recognising CSE and other forms of abuse.

In order to provide context, it is recognised that GP's only get around 10 minutes to see each patient and therefore in this case, a referral to specialist services to provide further assessment and support was appropriate.

Practice Learning
Children who have a history of abuse and neglect (ACE's) should have their mental health taken into account at each contact to ensure their mental health and emotional wellbeing are not being further compromised. Parental failure to engage with essential mental health appointments should be considered as possible medical neglect and risk assessed in terms of significant harm

Progress
Health – ACEs and Trauma informed practice are included in all level 3 training programmes including GP's. Workshops are under development to cover more in-depth training for relevant staff. In some areas training on the topic is being sourced by an external agency.
Schools – ACEs and trauma are included in the 2020 update to Keeping Children Safe in Education, which comes into effect on 1 September and all education staff will be expected to read this statutory document.
Children's Social Care – are commissioning a remote training programme on Trauma Informed Practice to begin in October 2020.
Adult Social Care – Trauma Informed Practice training can be run face to face or virtually but is not mandatory at the moment although staff are encouraged to attend.

8. Adolescent neglect and safeguarding

8.1. Definition of neglect

In line with the definition for Neglect in Working Together 2018, Olivia appeared to have been at risk of significant harm due to neglect because the child was experiencing the following throughout the timeline:

a) A persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.
b) A failure to protect a child from physical and emotional harm or danger

c) A failure to ensure adequate supervision
d) A failure to ensure access to appropriate medical care or treatment

The Children's Society acknowledged that, just like younger children, adolescents (age 11 – 17) are more likely to experience neglect at home than any other form of child maltreatment. There is evidence that some professionals struggle to identify adolescent neglect and are unsure what to do when they come across it.

8.2. Recognising Adolescent Neglect

Both mother and Olivia were well known to agencies prior to the timeline's initial event. There had been a long history of neglect in the context of parental substance misuse, domestic abuse and parental mental health issues. All this featured Olivia being left unsupervised at home alone, becoming a young carer when mother needed support, not having her basic needs met, being a witness to domestic abuse and drug taking and had protracted poor school attendance.

At the time just prior to the initial event (1) school had contacted EHASH with concerns about poor school attendance and concerns around mother and Olivia being uncontactable. This episode was viewed by EHASH as being an attendance issue and no further action resulted. At the practitioner learning event, school raised that they had been disappointed by the response taken by EHASH. However, school did not challenge the decision or take the opportunity to escalate concern to a more senior level.

Practice Learning
When Social Workers based at EHASH make decisions about safeguarding contacts and referrals which other agencies do not agree with, professionals should use the local area escalation policy to draw attention to their concerns to find a resolution in the best interest of the child. Agency safeguarding leads with experience in safeguarding children should be consulted for advice and support as necessary. Independent Reviewing Officers (IROs) are also a good source of advice and influence.

8.3. Recognising Private Fostering Arrangements

The initial event where Olivia was taken to A&E with abdominal pain resulted in 2 appropriate safeguarding referrals from both the ambulance service and A&E and these were triaged to Early Help for more information to consider what level of support the child and family required. The whole tone of concern by CSC appeared to be around the general needs of the child rather than taking steps to forensically investigate what was an unusual presentation for a 14-year-old child with a long history of neglect.

Early Help demonstrated concern for Olivia and made numerous house calls with no response. Deliberate damage to the property by unknown persons was highlighted and concern about the whereabouts of Olivia was a continual feature.

It became known that Olivia was staying with a family friend who lived a few doors away from her home address. She had been there for some time because her brother and his children had been living with Olivia's mother. This should have been viewed as a possible Private Fostering Arrangement which required a full assessment as per national minimum standards (Children Act 1989 & 2004)

The private foster carer (in this case the family friend) becomes responsible for providing the day to day care of the child in a way which will promote and safeguard the child's welfare. It is the duty of local authorities to satisfy themselves, through a full assessment that the welfare of children who are, or will be, privately fostered within their area is being, or will be, satisfactorily safeguarded and promoted. (Section 66 of The Children Act 1989)

Practice Learning
In cases where children are found to be living continuously with someone other than a close relative for more than 28 days, the local authority should be notified to enable a full assessment of the Private Fostering Arrangement to ensure that the child is being safeguarded and their welfare is being promoted.

A Private Fostering arrangement assessment would have found that the family friend was a vulnerable adult in her own right and was not best placed to care for Olivia. Also, MP became a "lodger" at the same house which should have been viewed as potential risk for both the family friend and Olivia.

8.4. Threshold for child protection under section 47

The Early Help worker came to a point where gathering further information was being overshadowed by other aspects of Olivia's life which started to overtake the original concerns such as mother being uncontactable and Olivia being missing from home and school.

A referral to CSC at EHASH was made by Early Help but this was declined with a request for yet further information about Olivia's living arrangements which had not been forthcoming from either Olivia or mother. Although Early Help did not completely agree with the decision made by CSC, because they felt they had tried everything they could to gain the information already, they did not challenge or escalate their concern through senior management.

The escalation policy was discussed at the practitioner learning event and most of the participants had not heard about the escalation policy or understood that they had a responsibility to challenge any safeguarding decisions made by other agencies that they did not agree with in the best interests of children.

A Private Fostering Arrangement- is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

Practice Learning
Professional respectful challenge and escalation of concerns where there is a difference of opinion should be expected practice. Promoting a culture where this is welcomed and encouraged provides a safe environment for children, workers and organisations.

Early Help continued to try to make contact with the mother and Olivia. Once they became aware that Psychological Services had become involved with Olivia the Early Help worker at the time closed Olivia's case file recording that Psychological Services would lead on the case. However, this assumption had been misplaced because Psychological Services had not been informed of this lead role and would not have been able to monitor the situation because of their counselling role and infrequent contact with Olivia.

Fortunately, a more experienced Early Help worker became aware of the closed case and requested the Head of Service to quality assure the case file. The service head found a number of outstanding concerns including Olivia being at possible risk of CSE. The case was referred back the Practice Manager (Senior Social Worker) at EHASH where it was allocated to a Social Worker for a child and family assessment.

A multiagency strategy meeting took place within timescales and is was agreed for a Child in Need (CIN) Plan under section 17 (Children Act 1989) to go forward to allow the social worker to complete a Child and Family Assessment and Police to investigate sexual activity.

A CIN meeting was convened but was limited because mother did not attend and the Social Worker left half way through the meeting to attend to something else. In view of the absence of mother and Social Worker the CIN plan could not build the momentum required to safeguard Olivia.

Practice Leaning
Child in Need review meetings are only effective when both parents and professionals are available to fully engage in the process. Consideration should be given to escalating to Child Protection in CIN cases where there is parental non-engagement and continuing risks to children are evident.

Two weeks after the CIN meeting, an event (4) appeared to trigger a more concerted move towards child protection arrangements when a social worker on a joint home visit with an Early Help worker witness 2 unknown males going in and out of the home looking suspicious before driving off. The Social Worker became worried that they may be connected to Olivia in some way.

This visit prompted the Social Worker to request the Core Group for Olivia to complete a Graded Care Profile (GCP) in preparation for a further strategy meeting to consider the case moving into child protection processes. There was no reference to the Adolescent GCP which is available locally and would have been relevant in this case.

The Graded Care Profile – is a widely used assessment tool designed to help professionals identify when a child is at risk of neglect. The Graded Care Profile assists professionals to measure the quality of care being given to a child in respect of physical care, safety, love and esteem on a graded descriptive scale.

At the Initial Child Protection Conference (ICPC), mother did not attend conference with Olivia as would have been expected. This was apparently typical avoidant behaviour which had previously been experienced by professionals. The conference unanimously agreed that Olivia should be subject of a Child Protection Plan under the category of Neglect.

The initial event (1), of an allegation made by a neighbour (family friend) that Olivia may be sexually active with an older male and the event (4) where men had been seen coming in and out of the home were mentioned in the conference minutes but neither of these events translated into concerns that Olivia may be being sexually exploited. In view of this, the Child Protection Plan did not include any actions pertaining to protecting a child from potential CSE.

The Child Protection Plan covered the standard areas concerned with Neglect. There was nothing in the plan relating to the vulnerability of mother and how to assess and address her needs with adult health services. Professionals at the conference reflected that mother had been offered support in the past but she had not engaged or cooperated with this which did not bode well for the future success of the child protection plan agreed.

Practice Learning

Child Protection Plans should cover all aspects of concerns covered at the conference and not just focus on the main category of abuse agreed. Plans should reflect the needs of all family members and address all the risks and concerns identified at conference. Actions should be clear and achievable and within a defined timescale. Contingency plans should be in place for action to be taken if the plan fails to address the needs of the child.

8.5. Difficulties in safeguarding adolescents

Research tells us that local safeguarding arrangements often have a “one size fits all system” and usually designed primarily to meet the needs of younger children maltreated within the family (Bilston 2006). The problem with adolescents is that they can often present as an “imperfect victim” in other words, they can typically be hard to engage, uncooperative and ungrateful, which makes addressing their needs a complex business. (Rees and Stein, 1999).

It had taken agencies 4 months from the first event to get to the point of multiagency agreement that Olivia required a Child Protection Plan. Several practitioners at the learning event agreed that the threshold had been met sooner but also agreed it was not unreasonable for CSC to want to complete the child and family assessment first.

The chair of the ICPC recognised the difficulties in safeguarding Olivia and recommended that CSC should obtain legal advice for a Public Law Order (PLO) for Olivia to be placed in care. This was a very reasonable suggestion given that there was no confidence that mother would cooperate with a child protection plan and Olivia was actively caring for her mother and with no one actively caring for Olivia.

The law is clear in line with statutory guidance and UN Convention on Children's Rights. Adolescents under 18 years of age should not be prejudiced against because of their age. Their wishes and feelings are important, but in cases where it is clear that no one is able to take parental responsibility for an adolescent child then CSC have a duty to take the option to accommodate the adolescent in line with the legal processes available.

It is usually preferable for adolescents to be accommodated voluntary (section 20) with another family member or family friend who can be assessed by CSC to care for the child. Foster care or children's residential care can also provide useful therapeutic placements.

Practice Learning
Neglect during adolescence is a complex area of safeguarding which requires sensitive handling and a brave response which may include the accommodation (voluntary or through the court) of an adolescent in line with legal requirements.

Whilst Olivia met the threshold for PLO, the decision by legal gateway and CSC senior management were to continue with a child protection plan. The reluctance to go forward with a PLO was because of the view that Olivia might sabotage any arrangement to move her away from her mother because of parent/child relationship and loyalty to her mother.

It was agreed to go back to legal gateway to review the situation again in 4 weeks. This did occur with the additional information that Olivia may have been sexually abused by an older male. The outcome remained unchanged using the same rational as before that Olivia's loyalty to her mother would place any new placement at risk of breakdown.

Olivia's wishes and feelings about PLO were not confirmed because no one had managed to speak to Olivia about the matter. Making assumptions about what children are thinking is not in the best interests of children. Children have a right to be consulted about decisions made about them.

The decision not to commence to PLO proceedings was not challenged and this left Olivia adrift with a Child Protection Plan that was not working because of parental non-engagement and with no legal court order to protect her. The situation became stalemate with no prospect of resolution.

This pattern on non-engagement with professionals and child protection plans by mother was a repeated theme throughout the child's life and should have been viewed as high risk. It was clear that no one was taking parental responsibility for the child and it should therefore have been the local authority's role to ensure someone was caring for Olivia. Again, practitioners at the learning event voiced their concern about the lack of PLO progress but no one escalated the situation to senior management for review and resolution.

Practice Learning
It is important that service arrangements for engaging and working with adolescents suffering neglect are locally defined and known to professionals working with them. Any form of prejudice based on age should be challenged through the local area escalation policy.

8.6. Mother's views on safeguarding arrangements

The Independent Reviewer spoke with mother as part of the review and mother was asked what she felt should have happened to support herself and Olivia. Mother explained that she was in a very bad place with her mental health and drug taking and what was needed was for agencies to "break in" and take over the situation. She told the reviewer that she felt like she had never got any support from the agencies and it was easy just to ignore them until they went away. She felt school did a lot of nagging via texts which did not really help get Olivia to school. What mother wanted was more practical support and someone to talk to and who would be able to understand how to help her.

Mother now has a key worker with the Sunrise Complex Safeguarding Team and this she said was the best support she has ever had. She appreciates the relationship she has with her key worker and this has helped her gain more support around her mental health from her GP.

Practice Learning
The importance of working with vulnerable adults who are parents using trauma informed practice. Working within an honest and trusting relationship is essential to managing changes in behaviour to improve parenting. Parents who do not engage with professionals should be viewed as high risk with the potential to cause ongoing significant harm to their children.

8.7. Protection of Olivia

The first 6 weeks following the ICPC there was a multitude of home visits by various professionals to try to engage mother and Olivia with no positive results. The work of the Social Worker who had been temporarily allocated to the case appeared to revolve around trying to find mother and Olivia at home. The Social Worker eventually found Olivia with an unknown male resulting in the police being called for a safe and well check.

The police supported the Social Worker on at least 3 occasions resulting in the new allocated Social Worker eventually managing to speak with Olivia and her mother. There was a conversation about the time Olivia had stayed with the family friend where Olivia told the Social Worker that the family friend gave her £70 every time, she got paid benefits and that Olivia would use the money to buy food and watch Netflix. The motivation as to why the family friend was giving Olivia this money does not appear to be explored or possible financial exploitation of the family friend (who was a vulnerable person) considered.

The Social Worker was instrumental in getting Olivia to school for one day and made a referral to Young Carers Service in respect of the care that Olivia was providing mother.

The Social Worker was able to review the living conditions on one occasion. Otherwise nothing changed with regards to neglect and very little face to face contact with Olivia took place.

As time progressed, the concerns of neglect became overshadowed by concerns of CSE and as previously described it was the police who finally brought an end to Olivia's suffering by arresting MP and using police powers of protection (PPP) to remove Olivia to a place of safety with other family members. Prior to MP's arrest concerns about CSE should have triggered a strategy meeting in line with child protection local arrangements.

Practice Learning When Child Protection Plans become overshadowed with more pressing concerns a strategy meeting should be called within 5 working days in line with local safeguarding practice guidance.

Following the initial arrest of MP (which occurred at a weekend) the police informed EHASH Emergency Duty Team who did not follow up on the welfare of Olivia stating this could wait until after the weekend. This does not appear to be in line with best practice guidance.

Practice Learning Adolescents who are victims of CSE require an early response for emotional support and possible sexual abuse medical at a local Sexual Abuse Referral Centre (SARC). A health assessment soon afterwards is advisable to identify sexual transmitted disease or any other physical or mental health issues.

9. Good Practice

There were a number of good practice examples recognised across the time period of this review as follows:

1. GP seeing Olivia alone at appointments to discuss issues around sexual activity
2. GP flagging system for children subject to child protection plans
3. Good communication by A&E and ambulance service.
4. Child Protection – Information sharing system available in the hospital A&E.
5. Police address markers on OPUS (IOPS) for children at risk
6. Experienced Early Help Worker recognising need for escalation following premature case closure.
7. Head of Service for Early Help who conducted a quality audit of the child's record and the escalation of safeguarding concerns back to CSC.
8. School welfare lead who acted as a mentor for Olivia and was available and helpful when Olivia felt she needed support.
9. Rota for daily checks (school and early help) at the home to try to make contact and engage mother and Olivia
10. Joint home visits between Social Worker and Early Help worker including out of hours
11. Examples of good child focus.
12. Plan to ensure that a Social Worker visited the home before Christmas and New Year

13. Positive engagement of Sexual Health Service.
14. Ongoing work of the Sunrise Complex Safeguarding Team.

10. Practice Issues

A practice issue is one that relates to practice matters for review at local provider practitioner level.

1. **Record Keeping** should include demographic details of the person in attendance with a child attending A&E when a parent is not present to include name, address, contact number, relationship with the child and reason why a parent is not present.
2. **Professional curiosity** – professionals should ask questions beyond what is on their organisations standard record keeping template. People expect to have a useful conversation with a professional and to be asked relevant questions.
3. Professionals need to be aware of the importance of **referring to Sunrise Complex Safeguarding Team** via EHASH as soon as CSE is suspected. This is to ensure the early availability of expert assessment and intervention.
4. When adolescents approach professionals with **concerns about issues relating to sexual activity –** professionals should consider the risk of CSE and know how to act accordingly.
5. Professionals should remember to **Think Child, Think Family.** When professionals are planning to safeguard children the adults in the child's life need to be considered in terms of their levels of vulnerability and their capacity to provide safe parenting.
6. Children who **"was not brought"** (formally known as did not attend) for essential medical appointments including appointments for mental health and behavioural issues **such as ADHD** should be considered as possible medical neglect.
7. Professionals should be aware of the **CSE tool** used locally to help them make a clear judgement of a child's risk of CSE.
8. When the **threshold for PLO is met**, judgements based on assumptions and the age of the child should not be the defining factor for delaying court action.

11. Training and Development

The following list of topics are areas for consideration in terms of training and developing the local workforce.

1. How children make a disclosure. Types of disclosure and how to support children to disclose.
2. Awareness of ACEs and principles of trauma informed practice.
3. Adolescent neglect and safeguarding
4. Working with parents and carers who may be vulnerable adults. (Think Family)
5. Private Fostering arrangements.

12. Conclusion

This SCR provides insight and reflection for the partner agencies of the Rochdale Borough Safeguarding Children's Partnership (RBSCP). This case is particularly useful for illumining the complexity of safeguarding adolescents and the challenge of recognising and managing cases of child sexual exploitation.

This review should be widely shared to promote learning across the safeguarding partnership.

Message to other young people from Olivia - if you are suffering from any form of abuse then you should always talk to someone who will listen to you and help you.

Recommendations

The following recommendations are for the consideration of RBSCP as follows:

Recommendation 1

RBSCP should continue to promote the work of the Sunrise Complex Safeguarding Team and request partner agency assurance that professionals working with children and young people are aware of:

- How to recognise CSE
- Understand what to do when they have concerns of possible CSE
- Adherence to the correct referral process for Sunrise Complex Safeguarding Team

Intended outcome *– To increase the awareness of recognising and acting on CSE concerns for the frontline workforce across the partnership.*

Recommendation 2

RBSCP should further implement the local Escalation Policy to instil confidence within the workforce and to promote the expectation for respectful professional challenge when there are differences of opinion about safeguarding issues between the agencies, including in cases where there is parental non-engagement

Intended outcome *– To increase the confidence and competence of front-line staff in escalating professional concern where there is difference of opinion for safeguarding individual children.*

Recommendation 3

RBSCP should be assured that the local area Public Protection arrangements for managing and arresting offenders out on warrant are being reviewed by probation and Her Majesty's Courts and Tribunal Service alongside improved arrangements already implemented by Police and Probation for the purpose of licence warrants.

Intended outcome *– To ensure the early arrest of offenders who are unlawfully at large within communities.*

Recommendation 4

RBSCP should be assured that the Voice of the Child is captured and acted upon, particularly in Public Law Order (PLO) proceedings, and that decisions made as part of PLO are not based on assumptions.

Intended outcome: *To improve the safeguarding of adolescents in the local partnership area.*

Recommendation 5

RBSCP should strengthen their safeguarding arrangements in the following areas:

- Promote robust information sharing with the allocated social worker or their deputy when there are new developments or concerns about children subject of child protection and child in need plans.
- Child Protection Plans should be escalated within the Local Authority when parents are not engaged in the child protection process.

Intended outcome: *To improve effectiveness of local child protection arrangements.*

Recommendation 6
RBSCP should consider how it can bring together multiagency learning and promote the utilisation of Adverse Childhood Experiences (ACEs) and Trauma Informed Practice (including attachment and relationship practiced) in future safeguarding children arrangements.
Intended outcome: *To develop the workforce in using a more trauma informed way of working which should benefit working relationships with parents and their children.*

Statement of Reviewer Independence

The reviewer, Kathy Webster is independent of the case and of Rochdale Borough Safeguarding Children Board Partnership.

Prior to my involvement with this Local Child Safeguarding Practice Review;

- I have not been directly concerned with the child or any of the family members or professions involved with the child, or have I given any professionals advice on this case at any time.
- I have no immediate line management of the practitioners involved.
- I have appropriate recognised qualifications, knowledge and experience and training to undertake this review.
- The review has been conducted appropriately and with rigours analysis and evaluation of the issues as set out in the Terms of Reference.

Signature:

Name: Kathy Webster – Independent Reviewer

Date

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