Sunderland Safeguarding Children Board

Serious Case Review

Young Person Rachel[1]

[1] *Not her real name*

Final 8th November 2017

Contents

1. Local Safeguarding Children Boards (LSCBs) and Serious Case Reviews

1.1. The main responsibilities of Local Safeguarding Children Boards (LSCBs)[2] are to co-ordinate and quality assure the work of member agencies to safeguard children. The statutory guidance[3], which accompanies legislation and underpins the work of LSCBs, sets out its expectation that LSCBs should maintain a local learning and improvement framework so good practice can be identified and shared.

1.2. In situations where abuse or neglect of the child is known or suspected, and children die or are harmed, LSCBs are required to undertake a rigorous, objective analysis of what happened and why, to see if there are any lessons to be learnt which can be used to improve services in order to reduce the risk of future harm to children. There is an expectation that these processes, known as Serious Case Reviews (SCRs), should be transparent with the findings shared publicly.

2. The circumstances which led to this review

2.1. Rachel and her family had been known to agencies since she was a very young child. As she grew older, concerns about her safety and well-being continued amid fears she was being sexually exploited. In summer 2015, at the age of 15, Rachel was accommodated by the local authority and made subject to a Secure Accommodation Order[4] following concerns about her vulnerability, safety, and well-being.

2.2. The Youth Offender Service (YOS) referred their concerns to SSCB, suggesting that the absence of co-ordinated agency involvement and the circumstances leading to her being placed in a secure setting amounted to significant harm. They requested that a SCR be considered by Sunderland Safeguarding Children Board (SSCB). A decision was taken by the retiring SSCB chair in September 2015 to undertake a SCR in respect of Rachel, but this decision was challenged by Children's Social Care (CSC), and the SCR did not immediately commence. The decision to commission a SCR was later reviewed in May 2016 by the incoming interim Chair of SSCB who confirmed that the

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[2] *Children Act 2004, s14*

[3] *Working Together to Safeguard Children 2015. HMSO*

[4] *A Secure Accommodation Order (section 27 of the Children and Young Persons Act 2001) authorises a local authority to restrict the liberty of a Looked After child and place them in secure accommodation*

circumstances which led to Rachel being made subject to a Secure Accommodation Order, together with concerns about multi-agency working, met the criteria for a SCR.

2.3. At the same time as the SCR for Rachel began in September 2016, another SCR which related to a 15 year old male who had been sectioned under the 1983 Mental Health Act also began. The Safeguarding Board partners agreed that both SCRs should have due regard to any common areas of learning and should also relate these to previous recent findings from other reviews concerning adolescents. The Review Team were also asked to take into account the changes already being embedded in Sunderland, especially given that the SCRs related to roughly the same period. The Terms of Reference were agreed as:

- To explore how well the system worked together in identifying, responding and meeting the needs of both young people.
- To determine what collective understanding there was in terms of the young people's vulnerabilities and the risks to which they were exposed.
- Building on learning from previous [and not dissimilar] SCRs to examine the barriers and system challenges for agencies and professionals in working effectively with young people with complex and challenging behaviours.
- How well were staff supported and supervised when working with these young people, and were they able to use evidence, research and good practice to exercise professional judgement in a safe and appropriate way?
- Identify required system changes to enable and support practitioners to work more effectively with older children like Mark and Rachel.
- Identify opportunities to learn from and improve frontline practice when working with vulnerable adolescents.

2.4. The Review Team were asked to consider the period between March 2013 when concerns were raised about Rachel and September 2015 when she was made subject to a Secure Accommodation Order.

3. Family Involvement

3.1. The Review Team took advice on three occasions to determine whether Rachel could contribute to this SCR but was informed by social workers and health professionals that Rachel's mental health was not good and she was, at the time of writing this report, extremely vulnerable. The Review Team therefore agreed not to contact Rachel directly and left open the possibility that Rachel may at some in the future want to know more about the SCR and its findings.

3.2. Attempts were made by the SSCB to involve Young Person Rachel's Mum in the process but she declined to be involved. Further attempts will be made to share the overview report with her and if she would want to add anything to the report regarding her views on the work undertaken with Young Person Rachel and her family an addendum to this report will be published.

4. The context in which this SCR took place

4.1. In 2012 Ofsted found children's services in Sunderland to be good but by 2015, children's services were placed into special measures when they were deemed by Ofsted to be inadequate. As a result of that rating, many changes to single and multi-agency systems were introduced, and other longer-term improvements are currently under way. Recent monitoring visits by Ofsted in 2017 have confirmed that steady progress is being made and there is clear evidence of significant and steady improvement.

4.2. To date, nine SCR reports have been published in Sunderland and 4 more are moving towards completion. Given that all these SCRs have reviewed practice up to and including 2015, it is not surprising that some of the findings also reflect those identified in the Ofsted report. The challenge therefore for this SCR was to ensure that any findings were viewed against a landscape of significant change within and across the authority which continues to emerge and develop. A Thematic SSCB report commissioned after the tragic deaths of two adolescents had also led to some significant changes in processes and systems in Sunderland, some of which have already been introduced and some of which, at the time of writing this report, are still in progress. There is an acknowledgment by SSCB that there is still much to be done in

relation to work with adolescents but it is encouraging to see this work has been identified as a priority in the 2017 – 2019 SSCB Business Plan.

4.3. In light of this context and in relation to the findings in this SCR, the Review Team has sought to identify where changes have taken place, where changes are in progress and where further work is still required. It must also be reiterated that this SCR is reviewing practice 2 to 3 years old, and whilst other SSCB reviews and the Ofsted monitoring visits suggest that the improvement journey is still on-going, there is evidence of steady progress being made to achieve better outcomes for children and young people in Sunderland.

4.4. The Review Team was grateful to the practitioners involved in this review who willingly engaged in this process and volunteered their reflections and professional insights, which have helpfully contributed to this report.

5. The Approach Used

5.1. A Review Team was established which included senior managers from all agencies which had worked with or knew Rachel and her family. The Agencies represented were:

• Independent Lead Reviewer	
• SSCB Business Manager	SSCB
• Detective Inspector	Northumbria Police
• Lead Policy Officer	Sunderland City Council
• Head of Educational Attainment & Lifelong Learning	Sunderland City Council
• Operations Manager	Youth Offending Service
• Chief Social Worker	Sunderland City Council
• Deputy Head of Safeguarding & Public Protection	Northumberland, Tyne & Wear NHS Trust
• Lead Nurse Safeguarding	STFT
• Community Safety & Safeguarding	Gentoo
• Named Professional for Safeguarding	North East Ambulance Service
• Safeguarding Children Lead Nurse & Designated Nurse for Looked After Children	Sunderland Clinical Commissioning Group

5.2. Senior managers from the above agencies identified practitioners from their own agencies who knew or had worked with Rachel during the period under review. These practitioners were known as the 'Practitioner's Group' and were invited to an initial introductory session so they could be briefed on the SCR process and offered an opportunity to discuss lessons from previous SCRs and how and where these had relevance for their work with Rachel.

5.3. The practitioners were extremely forthcoming about the issues they faced in their day to day work and their reflections of the challenges of working with Rachel and other adolescents were particularly illuminating. The Practitioners' Group later came together for a full day with the Review Team and other practitioners who worked with adolescents, to discuss and to explore whether single and multi-agency systems and processes were changing to better support existing work with adolescents.

6. Analysis of Practice and Findings

6.1. The purpose of Serious Case Reviews is to support improvements in safeguarding practice. This means it is not sufficient just to describe professional activity in a case or to identify elements of practice that were problematic, without explaining why they occurred. The analysis needs to provide an explanation of what influenced professional activity and decision-making at key points in the management of the case. The Review Team were aware of how hindsight can distort judgment but wanted to understand why certain actions and decisions would have made sense at the time and importantly, what systemic factors in place then, were still impacting upon practice in 2017. As the Review Team were asked by the interim SSCB Chair not to request Agency Learning Reports[5], the integrated chronology and the views and experiences of front line practitioners were key to understanding why some professionals acted as they did or why they did not act at all.

6.2. This SCR has not identified a significant contravention or action by any professional that was a critical factor in what happened to Rachel. Indeed there was evidence that many professionals with whom Rachel came into contact were concerned about her welfare and safety and sought to engage her or seek access to other services. The learning

[5] *This request was made as the agencies had only recently participated in two other SCRs and a Thematic Report relating to adolescents and concerns were expressed about duplication of effort and of learning.*

from the SCR does, however, invite and require a better understanding by managers and practitioners in education, health and social care of the interplay between adolescent choice and risk, especially in terms of sexual behaviour and sexual exploitation; the importance of shared assessment processes for children showing indicators of need or vulnerability; and the management of concerns and referrals when dealing with young adolescents whose life style, circumstances and mental capacity may be factors that require a more assertive and inquiring approach.

6.3. The Review Team was concerned to note that although a probation officer on secondment to YOS was the lead worker for this young person during her involvement with the YOS service, on return to her agency, she was not given permission to contribute to this review. Although concerns were escalated through to senior management in the Probation Service, the SCR was left without the benefit of contributions from that practitioner. Assurance has been provided by the National Probation Service that the learning from the work undertaken has been addressed in the agency.

Understanding complex behaviour in children and pre-adolescence

6.4. Concerns about parental neglect in the family are first recorded when Rachel was a very young child. The term 'neglect' is used to describe a variety of behaviours with varying impacts on children and young people but at its heart, '*neglect is essentially parental failure to meet the needs of the child*'.[6] The harm resulting from neglect can be wide-ranging and life-lasting and the longer a child is exposed to neglect, the greater the harm is likely to be. Neglect is also thought to be the most likely form of maltreatment to recur multiple times; its effects are cumulative.

6.5. As Rachel grew older, concerns about the physical and emotional care within the family continued and there were frequent reports about her parent's lifestyle and that children in the family were often left in the care of a slightly older family member. As a result of a concern about Rachel's sexualised behaviour when at primary school, a social worker undertook an initial assessment, but following discussions with family members no further action was taken. However, concerns about the behaviour of the children in the family continued to emerge.

[6] *Howarth J Neglect Planning and Intervention (2013)*

6.6. Pre-adolescent children with particular types of behavior problems (such as sexualised behavior) are a diverse group with differing levels of need who display a wide range of problematic behaviours that are beyond what might be considered 'normal' for their developmental stage. Such behaviours may emerge as a direct consequence of children's own experiences of abuse, or may represent a more complex and indirect response to trauma and neglect. Rachel's worrying behaviour at such a young age should have alerted professionals to the need for further more detailed assessments, if not under child protection procedures then certainly under child in need arrangements.

6.7. Rachel was diagnosed with ADHD when she was young and the naming of her 'condition' seems to have distracted professional's attention from thinking more deeply about what may have been happening in her life. The Review Team found that the frequent references in agency records to Rachel's ADHD in relation to her risk-taking and self-harming behaviours indicated that professionals accepted ADHD as a purely objective medical diagnosis. The risks for children with 'labelled conditions' are that their basic needs, which have nothing to do with their condition, can be disregarded, as the focus is more on the perceived problems arising from 'the condition'. In addition, very often, their parents are seen as deserving of extra support and sympathy rather than an assessment as to whether they are adequately meeting their children's needs. Reading through case notes, the Review Team found evidence that this was the case with Rachel and practitioners acknowledged that medical labels like ADHD could sometimes throw professionals off track.

6.8. If neglect is not routinely considered as a factor affecting young people with complex problems and behavioural difficulties, thorough assessments of the adequacy and quality of their parenting will not be made and this can leave them vulnerable. There is little evidence to suggest consideration of how the ADHD diagnosis came about and whether the experience and impact of adverse childhood experiences could have better explained Rachel's behaviours. These issues should have been explored in far greater detail then and in the many assessments to which Rachel was later subjected.

Finding 1*: Without robust multi-agency assessments, which focus on the child's care and experiences within the family, the needs of children who have been diagnosed with a 'condition' may be overlooked*

Findings previously identified in SCRs/Thematic Report: *Multi-agency assessments/Use of Assessment tools to aid professional judgment*

6.9. In 2014, the Office of the Children's Commissioner Concerns published the results of an inquiry into child sexual exploitation in gangs and groups. The inquiry found that '*...so many young people told…of their early histories of being sexually abused within the family home and of their experiences never being acknowledged*'[7]. Research suggests that children and young people are often identified as victims of sexual abuse following the provision of support for other presenting problems, such as challenging behaviour, substance or alcohol abuse or missing from health and education. Some of these are problems which may already have been present in the child or young person's life or environment; however, many of the factors which bring the child or young person to the attention of professionals may also result from the impact of the sexual abuse. Upon reading and listening to details of Rachel's background, it appears highly likely that Rachel was subject at an early age to some form of sexual activity/abuse and yet this and its impact on Rachel as a young child, and as she became an adolescent, appears at best to have gone unrecognised and at worst was disregarded.

6.10. The Children's Commissioner Inquiry suggests that while society now better recognises the existence of the sexual abuse of children by family members or people close to their family, and child protection practice has improved over the last two decades, the outcomes for children do not appear to have improved. The numbers of children made the subject of a Child Protection Plan for sexual abuse has fallen steadily over the last decade and it could be suggested that this decline, which is not commensurate with what we know about the overall prevalence of CSA[8], has resulted in, or has been the result of, declining levels of professional understanding and awareness in relation to the issue of CSA.

6.11. It is important that professionals can spot the signs and symptoms of sexual abuse. This is not a straightforward task – the signs and symptoms are not always clear cut, and there are few signs which very clearly and conclusively point to sexual abuse. However, Rachel's behaviour from such a young age and the nature of that behaviour towards other children was a very clear indicator that she had been subjected to or had

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[7]. *The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups 2014*

[8] *See How Safe are our Children. NSPCC 2016,*

witnessed some form of sexual activity and was acting out this behaviour with other children at school.

6.12. Overall, as with any type of abuse, there is an overreliance on children to come to statutory services to disclose abuse happening to them, but the focus must always be on professionals being attuned to changes in behaviour of children, their emotional responses and other indicators that those things are not going well in their lives. However, before any careful and sensitive outreach towards a child can take place, professionals must first consider a number of hypotheses to explain a child's behaviour and sexual abuse should always be considered even though it may be discounted then or later. In Rachel's situation, this appears not to have happened and the family's self-reporting to social workers undertaking the Initial Assessment that nothing was amiss in their family was accepted at the time and during conversations which took place in the following years.

6.13. The younger the person when problematic behaviours first appear, the more likely they have experienced adversities, such as being victims of child sexual abuse. If their trauma is never validated or addressed, or they were never supported towards recovery, research shows that as a consequence they can enter adolescence highly vulnerable to subsequent exploitation.[9]

***New Finding 2**: Child Sexual Abuse in the family environment will often come to the attention of statutory and non-statutory agencies as a result of a secondary presenting factor, which then becomes the focus of intervention. If professionals are not skilled or confident in their ability to identify child sexual abuse, children may be left at risk*

Understanding of risk in adolescence

6.14. The risks adolescents face are distinct. They differ from those facing young children and older groups, as do the impacts of those risks. Research[10] suggests it is not that the risks are greater or lesser than young children, it is that they are qualitatively different; for example sexual abuse at a young age is more likely to lead to sexualised behaviour, anxiety and hyper-arousal whereas sexual abuse or sexual exploitation in adolescence is associated with high rates of post-traumatic stress disorder (PTSD) and lower

[9] 'Children's Commissioner: Inquiry into Child Sexual Abuse in the Family Environment (2014)

[10] Child Sexual Abuse: Consequences and Implications Gail Hornor, RNC, MS, PNP DISCLOSURESJ Pediatr Health Care. 2010;

psychological functioning. Certainly, Rachel's past and present self-destructive behaviors appear indicative of some sort of childhood trauma, and there is strong evidence of PTSD which appears to have gone unrecognised.

6.15. The Review Team could find no clear rationale as to why protective action was not taken earlier for Rachel, i.e. before 2015; she was associating with known sex offenders, misusing substances and openly talking about risky sexual behaviours. Practitioners suggested that at the time sexual exploitation of children was not well understood locally or nationally despite statutory guidance being in place since 2009.[11] They added that volume of work, poor leadership and a lack of joined up working by agencies meant that work with Rachel just '*kept on going*', and without any good assessments or effective multi-agency planning, work was not as effective as it might have been. In times of competing priorities it is often work with adolescents that is deprioritised, especially if there is an organisational or sometimes a professional mind-set which holds the view that because of their age, adolescents are more '*resilient*' and can '*walk away'* from harm, unlike a young child.

6.16. Underpinning this view is an assumption that some of the risks encountered by adolescents are a result of choices that are '*freely made, informed and adult-equivalent'.* The Review Team was interested to note evidence of this assumption implicit even in agency records where Rachel's behaviours were described as: '*placing herself at risk*', '*associating with known sex offenders',* 'acting *impulsively', and 'choosing to self-harm'.* It is important that professionals and managers are supported to think carefully about the terminology used to describe the risks faced by adolescents. Language provides a medium for describing perceptual experiences and views and therefore has an extraordinary capacity to influence the way we think.[12] Professionals can compound misconceptions through their attitudes and inappropriate language and euphemisms – for example, by describing a 12-year-old girl as '*sexually active'* or describing a 35 year old male as a 14-year-old's '*boyfriend*' as opposed to an abuser or perpetrator. [13] Additionally, the response of practitioners may reflect faulty assumptions

[11] Safeguarding children and young people from sexual exploitation. DCSF (2009)

[12] *This is sometimes called the Sapir-Whorf hypothesis. ' Language may indeed influence thought' Jordan Slatev and Johann Blomberg. Phil Papers October 2015*

[13] *Dr Helen Beckett: 'Not a World Away' (2011) Barnardo's*

that young people or adolescents are more resilient than younger children by virtue of their age, despite having experienced more cumulative harm.[14]

6.17. The view that Rachel was 'placing herself at risk' should have been challenged in supervision and professionals supported to be more curious about the reasons why Rachel was behaving in this way. Research [15] suggests that where choice and behaviour are playing a part in the lives of children with complex needs, this is typically because one or more of the following factors or processing are at work or are interacting;

- Normal adolescent developmental processes (risk taking, peer influence, the desire for high status with friendship groups)
- Adaptive behaviour in response to previous maltreatment and adversity
- Societal attitudes and policies which increase risk or harm in response to adolescent choices and behaviour i.e. responding to youth offending which inadvertently reinforces criminal identity.

6.18. A challenge for professionals however was in determining which of the above factors better explained Rachel's self-harming behaviours. There is evidence that views of professionals were influenced initially by a perception that this was '*stroppy teenager wanting attention'*. Police records clearly indicate this view. The Review Team concluded that it was this perception, without analytical assessments, multi-agency collaboration, and challenge and quality supervision, which prevented earlier intervention.

6.19. It would have been helpful had these workers, supported and guided by their managers, been more curious about why Rachel was behaving as she did rather than try to manage or stop her destructive behaviour. Simple though this may sound, the Review Team did recognise this as a challenge in itself requiring, as it does, a definite paradigm shift in how services to adolescents are delivered. It seemed on reading through the integrated chronology for Rachel that social workers and other professionals were often drawn into a cyclical and constant pattern in which her behaviour determined what

[14] *Nicky Stanley (2011) Children experiencing domestic violence A Research Review*
[15] *Research in Practice, Developing a more effective response to risks in adolescence (2015)*

services were offered to the family, and when. Consequently, interventions were far too frequently crisis driven and appear to have focused solely on her presenting behaviours.

6.20. There is a growing awareness across the UK about child sexual exploitation (CSE), and since 2009 there have been an array of public documents aimed at local authorities to advise about how to recognise and respond to concerns about CSE. Even so, as late as 2014 professionals in Sunderland were slow to respond to the vulnerabilities of Rachel as a child whose behaviours indicated she was not just at risk of CSE, she was actually being significantly harmed through sexually exploitation. Practitioners suggested that even at that time the systems for reporting and responding to CSE were not well embedded in any agency and certainly not within a multi-agency framework. Ofsted reported in 2015 that the Sexual Exploitation and Missing (SEAM) processes for responding to and working with children at risk of CSE were not working and they were subsequently strengthened and replaced with Missing, Sexually Exploitation and Trafficked (MSET) arrangements. The SSCB has this area work identified as another priority in its 2017 – 2019 Business Plan.

Risk Assessments and Planning

6.21. Rachel was subject to numerous assessments during 2013 and 2015 but the Review Team could find no evidence of any quality risk assessments which sought to identify her needs or which captured views and information from Rachel herself or from other agencies such as YOS, CAMHS or education. It is these assessments which are so essential to the development of carefully designed and purposefully maintained child in need, child protection plans and safety plans. Although the focus of risk for Rachel centred on sexual exploitation, she was also at risk as a result of her childhood experiences, her disengagement with education and the fact she was misusing substances and alcohol.

6.22. A child or young person is considered to be at risk of significant harm if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent. Rachel was clearly not just at risk of significant harm, the harm was evident. Agency records highlight that whilst some risks to Rachel were well understood, they were not well managed. The purpose of risk management is to either identify potential problems before they occur, allowing professionals to make choices to avoid, minimise, or mitigate potential harm. By pre-

empting and managing risks, practitioners and managers make strategic choices about which types of risks to accept and which to avoid.

6.23. It is clear that until decisions were taken in September 2015 to seek a Secure Accommodation Order, professionals were of the view that risks to Rachel could be managed and the harm to her minimised, but without a robust multi-agency safety or child protection plan, Rachel remained at significant risk and highly vulnerable.

6.24. There is considerable research[16] which suggests that without the use of tools to assess risk, professional judgment is too often found to be flawed. The Review Team found no evidence that any risk assessment tools were used to aid professional judgment in terms of risks to Rachel. Practitioners told the Review Team that they were unaware of any multi-agency risk assessment tool they could have used with Rachel to inform their practice or decision-making and without this, agencies inevitably resorted to their own systems when undertaking risk assessments and opportunities to share information with other agencies were lost.

6.25. There is little to evidence that assessments took into account parenting lifestyle, and the family dynamics do not appear to have heightened concerns or led to any assessment process. Rachel was made subject to a child protection plan in 2013 and although this was stepped down to child in need status, it is difficult to identify what improvements or changes had been made in the family. Concerns that mother could not keep her daughter safe were even then apparent and remained so until Rachel was again placed on a child protection plan two years later. The '*rule of optimism'* that can affect assessment and decision-making in child welfare and child protection work is well documented.[17] Rachel's' mother at times appeared to be working with professionals and this, professionals acknowledged, gave the impression of collaboration. However, a seemingly co-operative parent such as Rachel's mum also has considerable power to disarm and distract professionals from what is or might be happening in their family. There is evidence that suggests that Rachel was seen within her family as the 'problem' and professionals mirrored this view in the way in which they intervened.

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[16] *www.rip.uk*

[17] *Humphreys C. and Stanley N. (eds) 2006. Domestic violence and child protection. Ofsted 2011b. Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*

6.26. The dilemma of how to work to a strengths-based approach, whilst also maintaining a critically evaluative focus on whether parental avoidance is happening is well documented.[18] It suggests that professionals often place too much reliance on what parents say and fail to consider that families can be resistant to contact from professionals and are able to develop skillful strategies for keeping them at arm's length. The possibility that this could be the case with Rachel was not explored.

Finding 3: *Without a purposefully designed multi-agency risk assessment tool, embedded within all organisations and accessed through a single point of access, professional judgments about risk are more likely to be flawed and this will reduce the likelihood of effective interventions leaving some young people vulnerable.*

Findings previously identified in SCRs/Thematic Report: *Use of Assessment tools including risk assessments to aid professional judgment*

6.27. The Review Team discussed with practitioners the single and multi-agency systems in place to support the production and maintenance of quality records and in particular why chronologies, an essential and invaluable assessment tool, were not used to better effect. The Review Team were of the view that practitioners were not being negligent in not ensuring that chronologies were maintained but that inadequate and failing ICT systems, pressure of work and not having enough time combined to make the production and upkeep of useful and effective chronologies less likely. Inevitably, this leads to criticisms when chronologies are either missing from reports or full of inaccuracies. Whilst professionals acknowledged that the time has yet to come when single agency IT systems communicate with each other, they also pointed out that there is currently no system or agreed process in place to support the production of shared chronologies within a multi-agency framework. They suggested this would be a welcome development and one which would have a significant impact on shared decision-making.

6.28. This issue has been raised repeatedly in SCRs, both locally and nationally. It will always be practitioners who must determine the key events in a case and the degree of impact on the child, and learning what should be transferred into a chronology is an important skill which managers must help all professionals to develop. Without functioning IT systems it will remain a challenging task. Creating integrated

[18] *Ofsted, 2008, Evaluation of 50 SCRs*

chronologies for SCRs for example is time consuming and costly but unless there are more simplified systems and clearer expectations that these must be produced when opening, reviewing or closing a case, practitioners will struggle to see the child's history and the significant events and transition in their lives. To do justice to chronologies,, practitioners need to spend time with families and the Review Team was told that very often that time is simply not made available to establish good working relationship with adolescents and their families.

Finding 4: *When concerns are raised about a child, a clear chronology of events can show agencies where risks lie, but unless practitioners understand how to build and maintain purposeful chronologies, and without clear systems to gather, record and share this information, the use of* ***chronologies*** *to inform good assessments and decision making is less likely to happen.*

Findings previously identified in SCRs/Thematic Report: *Use of Chronologies as multi-agency tool*

Multi-Agency Working and Collaboration

6.29. Rachel was made subject to two child protection plans and one child in need plan, but all three plans were of very poor quality. They did not clearly identify defined goals, expected outcomes, or the measures by which progress could be measured. In effect the plans were not SMART [19] and consequently they did not drive forward any sustainable improvements in Rachel's life. Despite the information available, the plans did not pull together how Rachel's emotional, physical educational and safety needs would be addressed by key practitioners. The plans that were used in Sunderland to protect and safeguard children at that time appeared cumbersome, complicated and were not child/parent friendly, making them difficult to follow and largely ineffective. Significantly, the Review Team shared that although the plans in current use were significantly improved, they had not been designed from a multi-agency perspective.

6.30. The importance of an integrated professional group being accountable for safeguarding children rather than confining the responsibility to children's social care was stressed in Munro's[20] first two reports on the child protection system (2010, 2011). Research[21]

[19] *Specific, Measurable, Achievable, Realistic and Timely*

[20] *The Munro Review of Child Protection: Part 1: A Systems Analysis, 2010; Part 2:The Child's Journey 2011*

suggests that the value of such inter-agency collaboration is widely accepted by professionals, including those working in adult services, who now are more likely to regard themselves as part of the child well-being system. However, ensuring that practice reflects these principles is not always easy, despite the support of national policy and guidance.

6.31. The Thematic Report commissioned by SSCB and published in September 2016, concluded that in Sunderland there was '*a safeguarding partnership seemingly operating at a basic and pragmatic level only, and working in parallel rather than in an integrated, cohesive manner* [22]*'.* Whilst this is clearly evident in reviewing practitioner involvement with Rachel between 2013 and 2015, there are also examples of some good practice and sound information sharing between professionals. Core groups took place regularly but the Review Team did not have a sense that professionals were working to an agreed plan and there is no evidence of any therapeutic work taking place with Rachel.

6.32. Practitioners intimated that within their own agencies there is still considerable reliance on their own agency procedures and recourse to multi-agency working is not always a first consideration. Other issues include barriers to specialist intervention and multi-placements, differing thresholds within each agency or differing interpretation of the thresholds. The threshold document within social care, practitioners suggested, is not user friendly and given that agencies have differing protocols the threshold document needs to be simplified in order to facilitate better multi-agency working. The Review Team found evidence that Rachel was referred back and forth between early intervention and CSC, and until the intervention of the YOS worker, Rachel's education needs were largely ignored for almost a year.

6.33. Practitioners acknowledged the benefits of multi-agency working but suggested that actually collaborating across agencies is not always easy, given time and other workload pressures. Research carried out by ADCS[23] suggests that many areas in the

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[21] *Children's needs – Parenting capacity Child abuse: Parental mental illness, learning disability, substance misuse and domestic violence DFE 2011*

[22] *Children's needs – Parenting capacity Child abuse: Parental mental illness, learning disability, substance misuse and domestic violence DFE 2011*

[23] *ADCS is a membership organisation. Its members hold leadership roles in children's services departments in local authorities in England. They specialise in developing, commissioning and leading the delivery of services to children, young people and their families, including education, health, youth, early years and social care services.*

UK are seeing an increase in adolescents such as Rachel coming to the attention of formal Child Protection services and without sound and effective multi-agency working, interventions are likely to be less than effective.

6.34. Practitioners stated that they knew the value of multi-agency working but suggested there was and still is a need for greater clarity as to when professionals should have recourse to multi-agency meetings outside CIN and CP processes, and what the status of those meetings should be. Agencies confirmed there remains a tendency to give greater priority to meetings called by CSC than by other agencies and this led the Review Team to conclude that more could be done to ensure that systems and processes better support multi-agency working.

Finding 5*: Multi Agency assessments and planning are key to supporting better outcomes for children and young people but this requires close collaboration between agencies and inevitably raises the question of who takes responsibility for coordinating this work. Multi-Agency collaboration did not work as well as it should have done with Rachel and this left her vulnerable.*

Finding previously identified in SCRs/Thematic Report: *Multi-agency information sharing and collaboration*

Mental Health Services

6.35. The work with Rachel as an adolescent was certainly constrained by an issue not specific to her but related to the legislative and professional framework within which professionals were working, namely the lack of placement options which could offer care and security to children with complex and demanding needs. As Rachel's behaviour became more concerning and her self-harming behaviours even more serious, professionals sought mental health assessments but were continually advised that Rachel was suffering from a conduct disorder and not a mental illness. This meant that professionals were unable to access a bed on mental health grounds to keep her safe.

6.36. The question of diagnosis of mental illness in young people is a vexed one. Adult mental health disorders such as schizophrenia or bipolar affective disorder occurring in adolescents are clearly psychiatric disorders, which affect the behaviour of the

adolescent and are treatable conditions. Young people who have suffered considerable emotional damage can present with behaviours of an antisocial nature and/or self-harm, and like Rachel, can sometimes too easily acquire the diagnoses of conduct disorder (and later in life, borderline personality disorder). These disorders very often respond poorly to mental health interventions in adolescence, and the lack of treatment for these conditions often leads to considerable frustration for parent and professionals.

6.37. Professionals face particular challenges when seeking placements which would meet all the needs of troubled young people. Such resources have always been expensive, and providers are selective regarding whom they will accept. This places an immense burden on responsible professionals in securing a suitable placement. This was certainly the case with Rachel as daily attempts to find an appropriate placement were unsuccessful; the case records suggest approximately 170 providers were contacted nationwide between July and September 2015 and only one offer of accommodation was made, but the timescales did not coincide with what was needed for Rachel. Faced with finding such resources in situations of extreme concern or pressure, it is not surprising that placements of marginal benefit are sometimes made, and occasionally decisions that are wrong in absolute terms are made. Even without hindsight, professionals knew that placing Rachel in a supported house, albeit with a bespoke package of care, was not ideal and had the potential to place her in even greater danger, but at the time options were limited and this was seen very much as the least worst option.

6.38. Although a decision had been made to obtain a Secure Accommodation Order for Rachel on welfare grounds, the fact that no accommodation was available offers a rationale as to why social workers pursued the possibility of obtaining a bed via mental health provision, but as Rachel was not and could not be diagnosed with a mental health disorder this in effect was not an option.

An adolescent –centred approach

6.39. The Review Team could find no evidence of any shared values and principles to govern specific work with adolescents in Sunderland. Reading through records and the integrated chronology for Rachel, the Review Team did find evidence of child centred work and the considerable efforts made by professionals who tried to engage with Rachel through various means. The Review Team and the practitioners considered that

even the term ‘child-centred’, while laudable in work with young children was not a particularly useful or appropriate approach when working with adolescents. These discussions highlighted the need for a different way of working and perhaps a different language when working with young people.

6.40. Practitioners suggested that for the most part the existing child protection/child in need systems do not adequately fit in with young people’s lives and experiences but in the absence of any different service designs they have to make the most of existing processes. It was also suggested that risks to young children are too often seen as more of a priority for services/intervention because adolescents are thought to be able to ask for help or ‘choose’ to remove themselves from risk situations.

6.41. The pathways leading to a number of harms that adolescents experience are however complex and do not easily fit with accepted child protection categories. Maltreatment in adolescence is no less harmful than maltreatment at an earlier age, indeed it could be argued that the opposite is true given what we know about the cumulative impact of harms over a given period and that adolescents are more likely to be subject to ‘polyvictimisation’ i.e. being victim to multiple forms of harm because of the external world/environment they also inhabit.

6.42. Harnessing and working with the risks of adolescent choices and behaviours is an essential aspect to them keeping safe, but existing child protection processes, public opinion and media coverage make this a particular challenge for practitioners trying to work with rather than for adolescents.

6.43. Whilst the Thematic Report urges a wide-ranging review of services to those adolescents who are known to be vulnerable, the Review Team would argue that there is an equal and perhaps more pressing need to examine how well risks in adolescence are understood in Sunderland and whether the right framework and services are in place to meet their needs. Research in Practice argues that a child protection system that is conceptualised primarily around preventing harm and maltreatment in younger children, who may be at risk within their own family, may not be well placed to serve the needs of adolescents and an adolescent- centred approach as opposed to a child-centred approach requires a different set of underpinning principles.

6.44. The Thematic Report states that '*without a clear statement of values guiding and underpinning the actions of those with responsibilities for safeguarding [young people] with often complex needs and at considerable potential risk, there lies an opportunity for inconsistency and outcomes for [these young people] will fall short of what good parents would accept as 'good enough*'.

6.45. The Review Team was struck by the similarities between the experiences of the four young people who were each the subject of SCRs during 2015 and 2016. Although there were different circumstances, each young person had, to varying degrees, experience of the following:

- Complex and difficult families
- Domestic abuse and/or family breakdown and family disruption
- Subject to child protection plans
- Appeared unable to make and sustain good relationships or develop strong attachments
- Self-harming, going missing, struggling to stay in education, and using substances, and 'legal highs'
- Emotionally vulnerable, distressed and depressed and at times in need of specialist mental health interventions
- Experiencing difficulties at school and using or being bullied through social media
- Associating with older men, and sexually active from a young age
- Professionals were unable to effectively engage with family members

6.46. Professionals acknowledged that many of the adolescents with whom they worked, or who were referred to CSC, also had these factors in common and they expressed some frustration in a system which was predominantly focused on younger children. Examples were given of having to record the 'voice of the child' but not having enough time to build a relationship with the adolescent in order to ascertain their 'wishes and feelings'.

6.47. Research studies[24] suggest that adolescents are not simply young adults or old children. The risks they experience, and the impact those risks have, are often very

[24] https://www.nap.edu/read/10209/chapter/2

different to those affecting other age groups, and as such, work with adolescents requires an identified set of specific principles upon which to build a distinctive and adolescent-centre approach. Despite the considerable efforts of professionals to engage with Rachel, it remains the case that overall, the interventions did not bring about the necessary changes within a timeframe which met Rachel's needs.

6.48. Research in Practice states that '*all too often services do not recognise or respond to underlying causes of crises, do not adequately 'work with the grain' of adolescent development, do not draw on the strengths of young people, their families and peers, and do not support practitioners sufficiently to manage the complexity involved with adolescent risk*.' The Review Team found evidence of significant amounts of professional activity and some good practice but little to suggest activity was in response to well thought out plans or clearly defined expected outcomes. The challenges and stresses of working with these young people require strong leadership; resources and levels of expertise which hitherto had not been evident in Sunderland.

6.49. Training and workforce development, including quality supervision, must ensure practitioners and managers have the skills to work with adolescent choice and complex behaviours and have opportunities to develop their understanding of the adolescent world, including access to technologies and social media. The issue of professional supervision was explored with practitioners, and the very clear message that emerged from this discussion was that practitioners in all agencies needed and wanted access to regular and quality supervision by managers well skilled to deliver reflective supervision.

6.50. Whilst some practitioners said they were satisfied with their supervision sessions others were far less so and cited sessions that were too often cancelled, reduced to 'catch up' conversations or even left to email exchanges. Practitioners were acutely aware of the demands placed on their managers but many felt that vacant, interim, or merged managerial positions significantly weakened managerial oversight of their work and supervision was not always given a high priority.

Finding 6: *The range and nature of adolescent risks are different to those facing younger children and the traditional response to such risks does not necessarily fit with young people's lived experience and research. The identification a multi- agency framework with clearly defined underpinning principles would support better practice for those professionals working with adolescents at risk of harm.*

Engaging Adolescents

6.51. Research[25] highlights clear evidence of the powerful and central role that relationships play in adolescent's well-being. The Review Team found evidence of some good practice through the efforts of committed workers from a range of agencies as they strove to engage, support and motivate Rachel. Listening to the experiences and concerns of frontline practitioners and their managers, the Review Team was struck by how difficult and frustrating it must have been at times to work consistently and constructively to help Rachel and her family. There is evidence that some workers tried hard to find solutions to Rachel's distress and negative core beliefs and were sincere in their efforts to offer support to her during times of what were daily crises.

6.52. However without a multi-agency understanding of how best to work with adolescents with complex and harmful behaviours, individual work was compromised. In addition, many practitioners spoke of not having the time or not having a managerial/organisation mandate, to prioritise the building of a relationship with young people, despite the volumes of research and young people's voices which say this is what they need before they can feel confident to engage with workers.

6.53. Practitioners involved in this Review said that the need to develop authentic and sufficiently intensive long-term relationships with young people is not fully recognised and has certainly not been part of the service response in Sunderland to date. The use of non-engagement as a coping strategy is known to be a common feature in adolescents. Professionals trying to help can sometimes interpret such behaviour as sabotaging attempts to help the young person and can too easily rationalise non-engagement as adolescent 'resilience', within a '*self-determining and young person's rights'* perspective. This can lead to a negative cycle of mutual rejection and result in a lack of effective help for the young person, leading to them becoming even more vulnerable. References in agency records to Rachel's banter and amusement when being interviewed by police or spoken to about the dangers of sexual exploitation may well have unwittingly led practitioners to feel reassured about Rachel's ability to keep herself safe.

6.54. Frequent changes of social worker or other key professionals are a constant complaint from young people. For adolescents who have strained or fragmented relationships with

[25] *World Health Organisation (2014) Health and wellbeing of young people*

their family, and particularly for those who have experienced abuse or neglect and have poor attachments to their parents, these changes in key professionals can be unhelpful or even devastating and militate against attempts to engage or support them in a meaningful way. Changes of social worker can also undermine care planning and contribute to placement difficulties. Rachel seems to have been passed back and forth between services, and the Review Team were unable to identify a professional who managed to establish a long term or meaningful working relationship with Rachel.

6.55. The evidence suggests that professionals struggled to engage Rachel to the point where she felt able to participate meaningfully in activities or with services. One of the key negative outcomes for Rachel, common to many adolescents who require services[26], may have been a lack of trust in adults, including those professionals who had attempted to intervene in her life. Rachel's pattern of seeking help and then withdrawing from help offered is also evidence of a lack of trust in the professional system which sought to protect her. This can so easily lead to a professional perception of a 'hard to reach' adolescent who 'does not engage' with services.

New Finding 7: *If authentic and sufficiently intensive long term relationships are not part of the service response to young people, and professionals are not actively supported to invest time in establishing these relationships, then interventions to reduce risk and promote resilience in young people is likely to be ineffective.*

7. The Situation now

7.1. The Thematic Review identified six overarching issues in relation to work with adolescents in Sunderland which also have a bearing on this SCR:

- Importance of values and principles to underpin multi-agency work with young people
- Need for specific services to vulnerable adolescents
- Recognition and response to Child Sexual Exploitation
- Assessment, Interventions and Planning
- Multi-Agency working

[26] *Brandon / NSPCC / University of East Anglia, 2013*

7.2. The response of SSCB to the findings from previous SCRs are captured in Appendix 1 and if these actions are implemented as stated, they will undoubtedly lead to improved practice across the Children's Workforce and will drive forward improvement in outcomes for children and young people. Care does however need to be taken to ensure that action plans, improvement plans, indeed plans of any sort, identify intended outcomes or impacts rather than just state what actions have been or are to be implemented. Equally important is that the processes through which changes or the desired results are measured are identified.

7.3. The Review Team asked practitioners for feedback about what if anything is different now. Responses indicated that were beginning to sense changes in their organisations and especially within Children's Services but they also indicated that developments were not involving practitioners in a way which was inspiring and importantly the changes were not happening fast enough and this left young people vulnerable.

8. Conclusion

8.1. The risks that adolescents face are particularly complex and wide-ranging but there is no reason to believe that they are any less harmful than those experienced by younger children. It is important to acknowledge that there are some young people in Sunderland who may not be having their needs met effectively by services, and this review and other more recent reviews relating to adolescents suggest more needs to be done as a matter of some urgency to work with young people to avoid, reduce and recover from risks they face.

8.2. There is however, a wealth of talent and knowledge across partner agencies, which needs to be galvanised through multi-agency working, strong leadership, and appropriate adolescent-centred policies, to create a more sophisticated model of risk prevention and protection for adolescents in Sunderland.

Appendix 1

Summary of Findings and Recommendations

***New Finding 2**: Child Sexual Abuse in the family environment will often come to the attention of statutory and non-statutory agencies as a result of a secondary presenting factor, which then becomes the focus of intervention. If professionals are not skilled and confident in their ability to identify child sexual abuse, children may be left at risk*

***Recommendation 1:** SSCB should*

a) Strengthen skills and knowledge base of the children's' workforce so that professionals are better equipped to recognise and respond to sexual abuse within the family network by March 2018.

b) Ensure whether services to young children with harmful sexual behaviour are proportionate and timely and are delivered in such a way as to reduce the risk of this behaviour continuing into adolescence and adulthood by July 2018.

***Finding 1:** Without robust multi-agency assessment, which focus on the child's care and experiences within the family, the needs of children who have been diagnosed with a 'condition' may be overlooked*

***Finding 3:** Without a purposefully designed multi-agency risk assessment tool, embedded within all organisations and accessed through a single point of access, professional judgments about risk are more likely to be flawed, and this will reduce the likelihood of effective interventions leaving some young people vulnerable.*

***Finding 4:** When concerns are raised about a child, a clear chronology of events can show agencies where risks lie but unless practitioners understand how to build and maintain purposeful chronologies, and without clear systems to gather, record and share this information, the use of **chronologies** to inform good assessments and decision making is less likely to happen*

***Finding 5**: Multi Agency assessments and planning are key to supporting better outcomes for children and young people but this requires close collaboration between agencies and inevitably raises the question of who takes responsibility of coordinating this work. Multi-Agency collaboration did not work as well as it should have done with Rachel and this left her vulnerable.*

***New Finding 6:** The range and nature of adolescent risks are different to those facing younger children and the traditional response to such risks does not necessarily fit with young people's lived experience and research. The identification of a multi- agency framework with clearly defined underpinning principles would support better practice for those professionals working with adolescents at risk of harm.*

New Finding 7: *If authentic and sufficiently intensive long term relationships are not part of the service response to young people, and professionals are not actively supported to invest time in establishing these relationships, then interventions to reduce risk and promote resilience in young people is likely to be ineffective.*

Recommendation 2 *(finding 1, 3, 4, 5, 6 and 7)*

In order to improve the effectiveness of multi-agency practice with adolescents who are at risk due to substance misuse and other forms of risk taking behaviour and/or abuse/exploitation, SSCB should:

a) Work with the Children's Strategic Partnership, the Safer Sunderland Partnership, and the Sunderland Safeguarding Adult Board to develop a multi-agency framework to support the development of resilience and improve outcomes for vulnerable adolescents. This framework should include:

- A strategy, robust systems, protocols, and tools for working with vulnerable adolescents

- Workforce Development opportunities to support staff to engage effectively with young people, better assess and understand issues of risk such as CSE, substance misuse, and transition.

This will be in place by June 2018.

Appendix 2a

Sunderland Safeguarding Children Board (SSCB) impact statement

What have we done, what are we going to do and what difference has it made/will it make?

A new Board structure was implemented from April 2017 with a new permanent Chair in place from May 2017. The new arrangements have strengthened governance arrangements to ensure high support and high challenge across the system, with clearer functions, a new structure, and newly developed and robust approaches to performance management, quality assurance, practice development, and the application of learning from research, evidence and review, as well as evaluating compliance with required standards of practice. The Board has been more effectively supporting (and challenging) the improvement programme for Children's Services and continually evaluating the improvements taking place, the investments being made and the differences these are making to children, young people and vulnerable families as well as supporting and challenging each partner agency's own improvement and development plans.

The SSCB has strengthened its MSET Sub Committee arrangements and this was confirmed by an independent review in 2016 which identified that the Board's MSET Subcommittee showed clear evidence of coordination, scrutiny, and challenge, including of the work of the MSET Operational Group, challenged partners to provide updates on their activities to address the risks to children, and raised issues about the attendance of key partners. The Reviewer concluded that the outcome of this work has been to deliver a focussed discussion of current, local safeguarding risks to children with clear leadership. The Ofsted Monitoring Visit Letter published December 2016 also found improvements concluding that "Sunderland's multi-agency arrangements to respond to children at risk of going missing and being sexually exploited and trafficked have been strengthened. The quality of information recorded and collated in the risk management tool ensures a well-coordinated multi-agency response. The child sexual exploitation referral tool is a comprehensive assessment document that has a strong focus on the views of the child. Arrangements for return interviews for children missing have been strengthened through the commissioning of a voluntary agency to undertake this work. Analysis of information and intelligence is informing preventative work for individuals and more widely. Examples seen were detailed and focused on risk, and were used well within the missing, sexually exploited and trafficked children meetings to inform practice on individual cases and also in relation to wider disruption activities.

Work undertaken by MSET Sub Committee includes:

- Multi-agency detailed audits undertaken in respect of 5 CSE cases and a sample of 20 CSE Risk Assessment Tools led to a review of the toolkit to strengthen practitioners' skills in respect of CSE cases. Both SSCB audits identified positive aspects of practice since the adoption of the revised tool and

the inclusion of professional judgement and the voice of the child have informed the continued learning and reflective practice. This gives a demonstrable influence of frontline practice on strategic direction. This was confirmed by practitioners who were part of this SCR and the Young Person Mark SCR.

- The toolkit is currently under consultation and implementation of the new tool aims to lead to more robust identification, assessment and intervention for young people who are being sexually exploited/at risk of CSE.
- In September 2016 the SSCB undertook a multi-agency Self-Assessment against the Joint Targeted Inspection Framework for children at risk of CSE or who go missing from home. The response included only 10 completed responses with a variety of approaches but demonstrated high levels of confidence in the awareness of CSE and the MSET arrangements across agencies, leadership and the SSCB and the overall effectiveness of the multi-agency arrangements were deemed Good by 80% of respondents. Gaps were identified in the ability to capture the preventative work undertaken and any work with adult offenders. These areas of work will be taken forward as part of the work of the Board and included in the development of a vulnerable adolescent framework.
- Challenged the commissioner and provider of the contract for the return home interviews for children who go missing from home and care. This has resulted in improved commissioning arrangements and improved provision for vulnerable adolescents. Performance data demonstrates an improved completion rate but further analysis of quality is required as outlined below.
- The Strategic CSE Co-Ordinator funded by Children's Services to work across the partnership delivered MSET (Missing Sexually Exploited and Trafficked) briefings to multi-agency practitioners and the voluntary sector, that is, 780 practitioners, 30 foster carers/adoptive parents, 220 taxi drivers, 15 licences, and 30 elected members received this training which also included changes to the Trafficking legislation brought in by the Modern Day Slavery Act
- Robust scrutiny and analysis of performance data relating to vulnerable adolescents to better understand the vulnerable adolescent population, their needs and how these can be addressed. The outcomes of this analysis has to date identified issues with the return home interview provider as mentioned above, a potential gender bias in respect of application of the missing vs. absence category by the Police. This relates to similar gender bias issues identified in this SCR with males being seen to be better able to protect themselves. The Board is developing a strengthened performance monitoring and assurance framework for the MSET Operational Group to more effectively focus on these areas.
- In recognition of the wider issues related to CSE the Board has ended the MSET Sub Committee and established a Vulnerable Adolescent Strategic Project Group (VASPG) which has a wider focus on the risks to vulnerable adolescents. The MSET subcommittee was sufficiently robust to support this shift and this is in keeping with the updated definition of CSE in Working Together 2015 (amended February 2017). The anticipated outcome is that there will be a more comprehensive and robust approach to addressing the

needs of vulnerable adolescents in Sunderland. This was originally for a 12 month period and as a result of this and the Young Person Mark SCR, the Group has been extended until September 2018

- Learning from this SCR and the SCR for Young Person Mark the Group has commissioned focussed reports from the commissioner and provider of the Return home interview contract November 2017, the Youth Drug and Alcohol Project (YDAP) in October 2017, the CAMHS Transformation work and the Transition Board. These reports are intended to provide an understanding of how effective these services are and what difference they making to children and young people, including when an adolescent is transitioning into adult hood.
- Met with the CSE National Working Group (NWG) regarding transitions and the learning that has been identified from this and the Young Person Mark SCR. The learning from the SCRs was shared with the NWG as part of research they were producing. The Board has agreed to undertake a benchmarking exercise in 2018 led by the NWG to have an evaluation of the arrangements for CSE etc. in Sunderland. This will provide the Board with a progress check; identify what difference we have made and where we can improve to better meet the needs of our vulnerable adolescent population.

The SSCB worked with the NSPCC to launch the PANTS campaign across Sunderland which is part of the SSCB preventative approach to addressing sexual abuse as it can be delivered by professionals and family members without any specific training. It aims to teach children to know how to protect themselves and raise concerns with family members etc. It has been very positively received across the partnership.

A joint conference on sexual abuse including links between sexual abuse and neglect and sexual abuse and sexual exploitation was delivered by the SSCB with the NSPCC. The learning from the conference is to be used to inform future work for the SSCB with the NSPCC around these areas of work.

The SSCB Strategic Plan 2017-2019 and the SSCB Business Plan 2017-2019 has been developed based on learning from these SCRs. The Board has 3 Service Priorities in these plans which are neglect, vulnerable adolescents and compromised parenting.

In conjunction with the Children's Strategic Partnership the Board is developing a framework for vulnerable adolescents which will address the key learning identified from this and the Young Person Mark Review.

Working with the other partnerships across the City to deliver a campaign highlighting where young people and adults can seek help if they are struggling to cope due to issues such as emotional or mental health issues. The aim of this campaign is to highlight that there are services available for our young people and their parents/carers and to reduce the incidence of self-harm and suicide.

A further SSCB audit of neglect practice is planned for 2018 to understand and asses if practice is improved around identifying and dealing with child neglect. The Board will continue to audit has effectively learning from services is being embedded access the partnership. An audit undertaken in early 2017 around the Learning from 6 Serious Case Reviews published in September 2016 identified some evidence that learning has been embedded. It has identified further work is needed to embed the learning. A second audit is planned for November 2017.

Individual Agency Impact Statements **Appendix 2b**

Sunderland Clinical Commissioning Group

The CCG Safeguarding Team will take a key strategic and operational lead role in sharing the learning from this review with all GPs and Practice staff across Sunderland to support individuals to meet their learning and competency needs in accordance with the Intercollegiate Guidance 2014 and their role and responsibilities. Young people will be seen by a highly skilled workforce who understand the importance of liaising and sharing information with professionals involved with young people, and make appropriate referrals in a timely manner therefore ensuring the needs of young people are met.

The aim of the Team's work specifically in Primary Care (GP) is to:

- Provide telephone advice and support to individual practitioners who have identified a possible concern about a child or young person – this can be measured by the number of calls to the team and evidenced on a tracker tool held by the team.

  Work is evolving with Together for Children – Sunderland to ensure that their Liquid Logic system can identify the separate agencies representing "health" and ensure feedback to relevant health leads on referrals which may be inappropriate or contain insufficient information. Should concerns be identified from TfC the Team will work with individual GPs/practitioners to improve safeguarding practice.

  There have been no quality assurance issues highlighted by TfC to the CCG regarding referrals from Primary Care since April 2017. In addition the annual primary care safeguarding audit cycle includes an audit into the quality of referrals submitted from GPs/practice staff. This will be undertaken November/December 2017.

- Support individual Practices in developing their internal systems and processes to monitor outcomes of referrals. This can be evidenced by the Practice visits undertaken by the Named GP (either planned or in response to queries, incidents or significant events) and the CQC inspection framework.

- Provide peer support and supervision to GP Safeguarding GP leads. Evidence - there is an annual programme of quarterly peer support sessions.

- Plan, deliver and evaluate bespoke training packages to those staff requiring Level 3 Safeguarding Children Training – Evidence - an annual training programme is in place and numbers of attendees and evaluation reports are compiled by the CCG Safeguarding Team – copies available on request.

Regular updates are also provided via Time in Time out sessions – a calendar of events is available.

- Disseminate immediate learning from reviews via a Primary Care briefing – this can be evidenced within the CCG files. Evidence - copies available on request.

- Disseminate safeguarding updates by a quarterly safeguarding newsletter – this can be evidenced within the CCG files – copies available on request.

- Seek assurance that the GPs in Sunderland understand their statutory responsibilities and respond to learning identified in reviews. Evidence – annual SSCB S11 audit, SSCB mystery shopper audit and the SSCB multi-agency audit programme. In addition to the multi-agency audits a range of single agency audits are undertaken with GPs – reports available on request.

Appendix 2c

Education and Schools

The learning has been focused on ensuring that safeguarding procedures and protocols are more robust and properly followed, particularly in relation to record keeping, information etc:

- Handover arrangements between the Link School and the excluding or dual registered school are conducted face to face with all relevant information shared and files handed over;
- All safeguarding information now recorded electronically at Link School on Child Protection Online Monitoring System (C-POMS) which is regarded as best practice system;
- C-POMS which is a referral system for any concerns records information in real time, requires receipted response and note of any further actions. Also produces electronic chronologies;
- No concern considered too small or insignificant to be recorded;
- Paper files no longer used (nb: Rachel's safeguarding file could not be found at the time the chronologies were being pulled together and has still not been found despite best efforts);
- As a result of the above procedures for archiving have also been tightened up for historic and paper files;
- Stronger professional curiosity and challenge to other agencies encouraged – and followed up in school safeguarding meetings

The timescales for above learning started at around the time that Rachel was at the Link School. Link School referred appropriately and were involved in strategy meetings with agencies and with Ferndean etc.

Appendix 2d

General Practitioners

1) **All GPs in Sunderland to receive information in training and briefing papers regarding the learning and recommendations from this review.**
    - On publication of the SCR a briefing document will be circulated to all GP practices.
    - Learning from the SCR will be highlighted in the GP Safeguarding Newsletter
    - Learning from the SCR will be discussed at the quarterly Safeguarding leads meeting; the Safeguarding Leads will disseminate the learning to practice staff.
    - Learning will be shared at future TITO events
    - There will be a coordinated approach to the dissemination of the learning to ensure all staff across primary care have knowledge of the issues identified.
    - The dissemination of the learning from this review will reinforce lessons learned from previously published SCRS in Sunderland in relation to young people with complex problems

2) **When 'fathers' attend surgery with a child or make contact about a child the legal status of the relationship to be established to determine who has parental responsibility**
    - When a child/young person attends surgery with a male reporting to be the father the GP will clarify the status of the relationship at each consultation and record in the child's records, ensuring that records contain correct and up to date information.
    - When 'fathers' attend the surgery requesting referrals to services GP/Practice will clarify the fathers information to ensure he is the biological father or has parental responsibility to ensure there is no breach regarding confidential information.
    - Young people to understand that their health records contain correct information about their legal status
    - The issue of taking a social history when fathers are registered with the practice has been identified and actioned in previous SCRs

Appendix 2e

South Tyneside NHS Foundation Trust

During the timeframe for this SCR Young Person Rachel accessed STNHSFT health services provided by the Young Person nurse, School Nursing Service, Looked After Children Nurse and STNHSFT safeguarding team. STNHSFT author identified a number of areas of good practice, namely prompt information sharing, and timely attendance at Multi-agency meetings as requested.
There was also evidence of challenge and escalation evident within the health records reviewed when concerns were expressed with regard to decisions made for Young Person Rachel.

The learning identified within the agency reflective learning report highlighted the need for the Young Person Nurse Health documentation to be amended to include advice and support with regard to sexual health.

Action	Outcome	Impact
The health assessment completed by the Young Person Nurse needs to reflect the sexual advice given.	The Young Person Nurse health assessment documentation has been amended and incorporates as standard practice advice and support with regard to Sexual health.	YP have a risk assessment completed which demonstrates advice and support either given or sign posted. The assessment form will be audited 2018.
Young person Nurse to be more visible across health and partner agencies.	The Young person Nurse is to be moved into the Sunderland School Nursing team. The YP Nurse works with YDAP who are now part of TfC.	The school nursing team will be able to access the YP as part of early intervention. This will take place in October 2017.

Appendix 2f

Northumbria Police

Rachel was interviewed in presence of mother following rape allegation. Police could have handled this more supportively and considered other options:

All staff understand the importance of listening to children and young people and have access to the policy at all times. In order to provide evidence of this: All staff receive training within their role on how to communicate with children. Specialist child protection officers have SCAIDP training and are subject to continuous professional development this includes ABE training where Officers and staff learn not to overpromise and not to lie to children in order to gain trust or persuade them to co-operate. During all contact with the Police during an investigation Officers agree a contract with the victim in line with their needs to ensure that the victims are listened to.

Dedicated rape teams and pilot schemes of dedicated Sexual Offences Liaison Officers (SOLO's) being deployed solely for initial contact for victims are now well established and have positively impacted on the service provided to children and young persons.

Young Person Rachel's drug taking, alcohol misuse, sexualised behaviour were indicators of sexual abuse and CSE. In June 2015, Young Person Rachel's behaviour was escalating. Missing from home episodes, drug taking, being given alcohol, this should have been flagged as a higher risk:

Northumbria Police have invested in a bespoke training package with Safeguarding Associates For Excellence (SAFE) for a targeted audience within the force which will be mandatory for all staff involved. This training incorporates all aspects of CSE including recognising the signs.

Northumbria Police now have two dedicated Missing from Home Coordinators. Their role includes the flagging of missing children and young persons to MSET. This dedicated 'spoc' has resulted in improved liaison between partners in relation to flagging and escalating identified risks to children and young persons.

The SSCB MSET Operational Group was focussing on victims and not using disruption tactics as robustly as they could. More disruption work should have been done around father. There were 3 allegations of rape made against father:

The MSET Operational Group is now more established and robust providing improved safeguarding to children and young persons.

Appendix 2g

Together for Children – Children's Social Care

Project/Action	Activity (how much)	Outcomes (how well)	Impact (what difference your action has made/will make)
1. To make sure the Together for Children (TFC) children's social care workforce is fully aware of lessons learned from previous serious case reviews involving adolescents	A series of workshops have been delivered to all frontline staff through team meetings (x11) covering the recommendations set out on the single agency action plans Young Person(s) K&I Worked collaboratively with partners to design an adolescent risk management panel (proposed implementation April 2017)	The TFC workforce will be aware of the risk factors associated with vulnerable adolescents and will have the knowledge and skills to assess, respond, and reduce the risk/s More streamlined multi-agency response to adolescents who are assessed as at risk	Young people receive an appropriate and timely and co-ordinated response from all agencies that reduces risk and creates the opportunity for maximising positive change. This will be evidenced in the outcome of audits, quality of assessments, evidence of timely access to services in children's plans (child protection, child in need, looked after and pathway plans) The impact of the new arrangements will be monitored by the group and shared with the SSCB

Project/Action	Activity (how much)	Outcomes (how well)	Impact (what difference your action has made/will make)
	Reviewed MSET procedures and risk assessment tool Planned e safety training for staff for October and November 2017		 This has to be put in place – planned for October and November 2017
2. Child Protection (and Child in Need) Plans for adolescents are appropriate and fit for purpose			Improving the quality of plans leading to improved responses and access to services resulting in improved outcomes for young people.
• The reasons for child protection plan should be carefully considered and categorisations appropriate	The IRO service to receive training in respect of Child Protection and Adolescents – training plan being developed for implementation 2017/8	More appropriate categorisation of Child Protection issues eliciting more appropriate services	This will be evidenced through audit, feedback from young people, quality of commission information
• Access to appropriate services in a	Collaborative working with partners to design	Coordinated and timely response from all agencies	Panel to commence in Spring 2017 – evaluation built in to the pilot

Project/Action	Activity (how much)	Outcomes (how well)	Impact (what difference your action has made/will make)
timely way is paramount in keeping young people safe	an adolescent risk management panel (proposed implementation April 2017)		

Appendix 2h

City Hospitals Sunderland

Within the set timeframe for the SCR Rachael accessed the services via the adult emergency department (ED) when she self-harmed and alleged rape. During these times she was either subject to a child protection plan or a looked after child, where she would be seen for her LAC review health assessments.

Although action was taken on all ED attendances there was a general attitude from staff that she was a regular attender with a mental health problem which would be the responsibility of the CYPS team to assess.

The learning CHS is in respect of her attendance into Adult ED with lack of professional curiosity, lack of awareness to vulnerability when looked after child and understanding adolescents behaviour.

Action	Outcome	Impact
Within patient records children and young people who are known to be LAC in Sunderland will have an alert which will alert staff with information on what they need to do.	The paediatric liaison nurse has oversight of all children and young people less than 18 years attending ED and paediatric and alerts make this clear.	Children who present into ED and are known to be LAC the paediatric liaison nurse shares this information with the LAC Named Nurse and Social worker. The audit is 100%
For under 18 years ED documentation to include an adolescent risk assessment tool. HEADSSS - Home, Education, Activities Drugs/alcohol, Sexual relationship, Social history and Suicide risk assessment	HEADSSS assessment is within ED records and training has been delivered to staff and is within safeguarding children level 3 training.	Level 3 training is 90% compliant. HEADSSS compliance audit to be completed as part of audit cycle 2018.
Improve mental health service access when children/ young people present into ED with mental health issue.	Introduction of a 24/7 CYPS service within CHS which can see children at the point of need.	NTW now see children within 1 hour of presenting into ED with mental health issues. This is part of the wider Mental Health National Project to have a psychiatric liaison within all major acute providers by 2020.
Set up a CSE task and finish group within CHS to include ED staff, sexual health and safeguarding.	CSE task and finish group set up and implementation of HEADSS progressed, sexual health referral pathway from ED to sexual health/GUM in place.	CSE task and finish group now monitoring group, who meet 6 monthly to address gaps in service. Increased activity from ED to sexual health services noted on their performance data in past 3 months.
Level 3 training to LAC update and reflect learning form SCR.	Part of safeguarding children mandatory training.	Increased awareness of what LAC through training with compliance at 90%

Appendix 2i

Youth Offending Service

The Youth Offending Service worked with Rachel for a significant period of time as well as other family members. During that time Rachel and her family were compliant with the expectations of her Court Order and it was also believed that further additional support had been offered successfully to her family following a referral to the Family Intervention project. What has become apparent is that staff did not question whether the family's engagement was disguised compliance. Since then a workshop has been held for all staff in March 2017 which uncovered topics such as disguised compliance, we have also revisited in supervisions with staff practice guidance on signs of neglect in teenagers. The impact of this is that staff should be better able to identify neglectful parenting etc. and refer parents for appropriate support including specific parenting programmes now in place through Early Help. We will review how referrals can be monitored.

Staff were aware that Rachel was vulnerable and therefore potentially at risk of exploitation. At the time MSET procedures were not fully developed but staff were engaged and knowledgeable about the issue including existing processes within the local authority. There was no identification of on-going abuse or exploitation in this young person's case but YOS staff continues to contribute to and attend MSET meetings regularly.