Report to Kirklees Safeguarding Children Board

A multi-agency case file audit to consider a baseline assessment of performance and assess the current response within Kirklees to issues of child sexual exploitation.

Executive Summary

Audit Report Author: Joanne Simpson
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Exec Summary Author: C.J. Rhodes
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What is Sexual Exploitation?

The exploitation of children & young people under 18 involves exploitative contexts and relationships where young people (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing and/or others performing on them, sexual activities. Child Sexual exploitation can occur through use of technology without the child’s immediate recognition, for example the persuasion to post sexual images on the internet / mobile phones without immediate payment or gain. In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationship being resulting from their social/economic and or emotional vulnerability (Source: Department for Education 2012)

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1. Terms of Reference

Working Together to Safeguard Children (2015) includes a statutory duty for Local Safeguarding Children Boards to evaluate multi-agency working through audits of case files. There is also a duty for LSCB’s to assess responses to CSE and missing children.

The Department for Education Document “Tackling Child Sexual Exploitation” (March 2015) stresses the need for LSCB’s to carry out regular assessments on the effectiveness of local responses to CSE.

Kirklees Safeguarding Children Board (KSCB) undertakes multi-agency audits to consider how effectively agencies work together to support families, and to identify lessons that may be shared to improve systems and/or multi-agency practice.

Kirklees CSE Workstream has the strategic responsibility for the development and implementation of the District’s response to CSE. The strategy for 2015 included undertaking a multi-agency audit to be used as a baseline assessment of performance and assess the current response within Kirklees to issues of child sexual exploitation.

The audit addressed:

- Referral and Identification of Risk:
- Quality of Assessments:
- Quality and Effectiveness of Plans
- Outcomes

2. Methodology

The KSCB Safeguarding Co-ordinator for Child Sexual Exploitation and the Safeguarding Coordinator for Review, Procedures and Performance designed an audit tool to enable representatives to consider individual cases in a consistent way.

The audit tool was sent out to twelve agencies represented on the CSE Workstream. 120 audit forms were distributed for completion. 57 audits were nil return (40 of which were from agencies with no involvement with the young people). 63 audits were completed and returned and form the evidence base for this report.

An initial summary of findings was produced and considered by the CSE Workstream on 8th of July 2015. Agency representatives participated in a group review of the draft findings on the 3rd of August, and the final report was presented to the CSE Workstream on 16th of September, 2015.

Agency representatives involved in the completion of the audit and/or consultation during the production of the audit report were drawn from:
Children & Young People Services (D&A) , (Looked After)  
Locala Community Partnership  
West Yorkshire Police Child Protection Unit;  
Integrated Youth Support / YOT  
CRI / the Base  
Local Authority CSE Manager  
Learning Service  
Greater Huddersfield & North Kirklees CCG  
Multi-Agency CSE Hub  
Local Authority LAC / Corporate Parenting  
Barnardos

3. Cases

Ten cases were identified by the CSE manager across the risk matrix of CSE during week commencing 11th May 2014. The sample was all female in the age range 12-18 years. The ethnicity was 6 white British, 3 Asian, and 1 dual heritage.

3 young people were deemed at high risk of CSE, 4 medium risk and 3 low risk.

Of the cases audited the legal status of the children was as followed: 5 were looked after Children, 3 were child protection; and 2 were Child in Need. Of the Looked after children 2 of the young people were placed out of the authority, 1 in a residential setting and 1 in foster care. 2 were placed locally in residential units, 1 a local authority provision and 1 independent residential unit, and 1 young person was placed with foster carers.

4. Overview of Audit Findings

Family structure

Auditors where asked if they found a family history on the case file. Social care on the whole had this information; schools had full chronologies on all their files of the children's history. Other partner agencies had limited information on family history.

In respect of commonalities of information taken from all the audits submitted, a picture of potential contributory factors was developed. The lead auditors were able to identify the following.

- 90% had missing episodes
- 90% had displayed risky sexual behaviour
• 40% had misused substances or alcohol
• 70% had emotional health issues or episodes of self-harm
• 60% were LAC or placed with an alternate carer
• 60% had experienced domestic abuse
• 80% had previous Social Care concerns / intervention
• 50% were involved in offending at some level
• 20% had suffered a close family bereavement
• 70% had experienced family breakdown or dysfunction
• 80% were not fully engaging with services
• 80% had been regularly absent from education

**Referral & Identification**

**What we do well**

When CSE was identified as an issue the correct referral processes and documents were used by referring agencies. There was a timely joint approach by the CSE Hub in all cases. Joint visits were undertaken in all cases by police and social care and s47, and strategy discussions initiated where appropriate.

Operational meetings took place on all cases assessed as medium or high risk, which is in line with procedure from January 2014. For those cases with actions prior to the new procedures the findings would indicated that low level cases were also considered at the operational group.

Risk Assessment Plans were completed on the majority of cases on social care files.

There was good evidence through the audit of disrupting perpetrators via seizure of evidence, prosecutions, SOPO, PPO and use of harbourer warnings.

One case dealt with at CIN level, agencies raised challenge about as they felt it was clearly Child Protection; this case eventually became LAC.

**Considerations for improvement**

Statutory checks were recorded on 4 out of 10 cases on Police records

Perpetrators were not linked on Social Care systems in several cases. There was one case where perpetrators where identified on this school file.

Good evidence was identified of stepping up and down the level of risk and service provision upon receipt of new information. However information sharing was not always apparent and partner agencies were not always informed of this.

Partner agencies were not always informed of the outcome of referrals
There were concerns from the audit of those cases which were identified or stepped down to low risk. There were no formal plans under which their needs would be reviewed. In two cases identified from the school audits, work was continuing with a young person deemed low risk, but there was no formal plan or review process in place.

90% of the audit sample evidenced that there were missing episodes. There was little evidence of return interviews being carried out following missing episodes\(^1\).

80% of the sample had absences from school, however only 2 schools had plans of action in place to address this.

Honour Based Violence was not evidence within the partner agency tool however in one case this was logged as a risk factor.

**Quality & Effectiveness of Assessments & plans**

**What we do well**

There is good evidence that cases have been escalated and stepped down appropriately.

There is effective case flagging, particularly within social care, health and police.

There was evidence of good communication when young people have moved out of area. However information held by host authorities is not always on file in Kirklees.

There is much evidence of communication between professionals but this is not always formalised and structured.

There is good evidence of schools supporting young people post 16 and helping with transition to new educational provision. There is also good evidence of schools transferring safeguarding records between schools. One school also developed a risk assessment in relation the transition process.

**Consideration for improvement**

The most significant findings were that Risk Management plans were not on partner agency files. Agency staff with access to care first (social care system) would have this information, but the majority of partner agencies did not. There was one case were the Risk Management plan was on a school file.

Auditors reported that there were often no timescales set within plans and a lack of allocation of specific tasks. This was identified in 6 of the ten cases, with young people who were assessed across the risk matrix. The plans which reflected this were LAC, \(^1\) Missing is currently being reviewed and work is being undertaken to address return interviews. Guidance has also been developed for schools to aid them in addressing the issue of absence.
CPP, CIN; none made reference to the Risk Management plans which should be reviewed and integrated into other plans relating to young people.

TYS and CRI develop their own plans for work with children which were not cross referenced with CSE Risk Management plans. In CRI they also use their own risk matrix, and in one particular case working with a child at a different level to the Risk Management plan (due to not being informed of the changes in the risk level of the young person). TYS use the Operational meeting discussion to classify the level of risk on their plans. It is a concern that there are multiple plans for a child e.g. a looked after child who is assessed as high risk CSE could potentially have 6 plans, a LAC Plan, Risk Management plan, CRI plan and TYS Plan, Health plan and Education plan.

TYS Plans often lack emphasis on risk and are not SMART. In 8 out of a potential 9 cases the auditors highlighted this as an issue. An example of this was a plan that lacked emphasis on risk factors and did not address work around CSE even though the child was assessed as medium risk.

Currently Kirklees procedures state that if a child is deemed at medium or high risk of CSE they are brought to the operational group and a risk management plan develop to address the issue of CSE. The process is then for the Risk Management plan to be reviewed alongside any other plan pertinent to that child i.e. looked after child review, child protection review, child in need. The audit found that in all of the cases this was not taking place.

Plans of work within non statutory agencies appear formulaic. Protect or Respect (an awareness raising tool) has been used with children assessed as medium and high risk of CSE. There is no evidence of use of the Barnardo’s workers in support of these plans bringing their expertise to the role.

Contingency arrangements within plans were limited. Non statutory agencies do not take ownership of contingencies and consequences which was stated in 6 of the audits. The stated reason was that they were not statutory. Another agency identified that a “contingency noted but not explicit” and in another case, the contingency plan of S47 was not followed when further concerns arose, leaving the young person at increased risk.

Contingency in respect of young people identified as low risk were also a concern. On cases that were stepped down or assessed as low risk there were no specific plans. One case stated that “Assessment identified risk and support needed, but no formal plans put in place”. This lack of contingency leaves young people vulnerable.

Some concerns highlighted in the audit were that plans were not fully incorporating risk factors post age 16. One case reflected that there was more focus on domestic violence than CSE (child assessed as high risk). Plans for this cohort of young people were described as not clear / or no real plans in place. There are also some issues re
consistency of health input post 16, particularly with School Nurse intervention ceasing.

Duplication of work was also evident throughout the audits. There were a number of agencies involved with young people, which caused duplication of work. TYS undertook sexual health / self-harm work whilst Health was involved. Two cases from the audit saw agencies pulling out due to others doing the work.

The number of professional involved became overwhelming of the young person. Two of the cases evidence that plans with less professional input had more positive results. It was also identified that the strongest working relationships are not always utilised. In one particular case a TYS worker was asked to withdraw by social care as they felt the child was becoming too dependent; the child was high risk CSE. Following the departure of the worker there were another 6 episodes of the child being ‘missing’.

An example from the audit of the implications for the above situations was recorded in a session with a young person at school. During the Christmas period the young person became vulnerable even though there were a number of services involved. The young person stated in the session at school:

*I have not seen my TYS worker since September
I could not remember the last time I saw S (does not state agency)
I have not seen Base since the week prior to Christmas
I tried to contact the police officer involved in case and left a message
I spoke with the Hub social worker prior to Christmas. The case had been moved to care management and there was no social worker involved
My mum is away from home for a period of time over Christmas,

I spent most of the Christmas period hanging around town. I met a 30 year old Asian male who I gave my number to, he was texting me asking if I smoked cannabis and on New Year’s Eve he texted me inviting me round to his house.

This situation identified a number of agencies involved with a young person yet there was a lack of support over the holiday period, and there was lack of contingency which increased the vulnerability of the young person already assessed at high risk of CSE.

The audit also found there was a lack of assessment in respect of young people demonstrating sexually harmful behaviours against other young people. Three cases which were audited highlighted children with sexually harmful behaviours. They were all LAC children (one becoming LAC post the behaviours). No specific assessment was undertaken or commissioned to identify the young person’s vulnerability and risk to others. Commissioning of service was also identified in a further case where a LAC young person was awaiting therapy deemed essential to her welfare which had not been commissioned.

Specific tasks and timescales were not always apparent from operational meeting minutes; they appear to be more of an intelligence sharing forum. On one particular
case the auditor recorded that they attended 4 operational groups where a child was discussed. Of the four meetings three had no actions recorded, the forth meeting stated professionals to continue work with child.

The minutes of operational group meetings were sporadic on the files of many agencies, particularly schools (only one school had this information). This was a similar situation in respect of child protection plans, and conference and core group minutes.

In all 10 cases there was a lack of focus on the young people’s emotional difficulties within operational group and assessments. There are wider issues for these young people which have contributed to the CSE risk, and there is a lack of holistic approach particularly in respect of early intervention and response to trigger factors this results in the plans often being reactive to crisis with focus shifting away from the overall needs of the child.

Four of the 10 ten cases identified CAMHS as an agency to undertaken work with a young person but there is no evidence that this work has taken place.

**Outcomes including the quality of supervision**

**What we do well**

Feedback sought from young people and their families within CRI & TYS via exit forms.

There is a wholesale lack of engagement with young people but many agencies have persisted in their attempts, using different strategies.

A number of partner agencies undertake internal audit of case files on an annual or six monthly basis.

Files are generally in good order but some information has been lost due to IT changes.

**Consideration for development**

A number of agencies did not offer reflective supervision. Supervision in the broadest sense would equate to emotional support, case reflection and professional development.

- Of the 9 schools audited one school was offered weekly supervision and monthly clinical supervision, which is good practice. However no notes were made and retained on the child’s file.
- TYS identified that there was a lack of reflective supervision and management oversight of their cases.
- CRI identified that there was some supervision but not sufficient\(^2\)

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\(^2\) Feedback from CRI subsequently stated that ‘not sufficient’ was not in reference to supervision but to the level of contact with a young person where the contact was via school in one of the cases audited.
• Social care supervision has taken place, but did not focus on CSE, or was irregular, with some missing sessions
• Health stated that supervision is available if the worker wishes to access it, therefore not mandatory
• Police undertake case management approach

It is acknowledged that supervision has its history based in the social care arena. However, reflective supervision is recognised as a key component of working with CSE cases. This has been raised as an issue in the Children Commissioner Report 2013 ‘Someone to listen to’ and the Ofsted Thematic Inspection Report ‘It couldn’t happen here could it’? 2014.

Feedback and involvement from young people and their families was often lacking throughout the process largely due to lack of engagement of the young person. Gaining this would appear to work better in non-statutory agencies.

There is a lack of clarity about data collection for KSCB and how and what data should be shared.

5. Recommendations for Further Developments

i. The Risk Management plan should be shared as a matter of urgency with partner agencies involved with a child, and updates forwarded.
ii. Increased focus at operational group on reviewing and cross referencing multi-agency plans and roles to ensure risks are fully addressed. Plans should include timescales, measurable outcomes and contingency plans ensuring work is not duplicated and holidays periods should be planned for and support made available.
iii. Minutes of operational groups meetings should be distributed via the representative at the meeting (particularly to individual schools). Minutes of strategy meetings should also be distributed to all agencies involved with the child whether they attend or not to ensure that are able to complete any tasks which may be allocated to them.
iv. Plans which are stepped down to low level or assessed as low level should be dealt with via the single assessment process to ensure that work undertaken is within a framework, which offers review, and managed timescales of work.
v. Partner agency tool should incorporate children with sexually harmful behaviours, and appropriate assessment undertaken to address the vulnerabilities and concerns for the young person. The Risk management plan should also reflect other specific risk factors such as honour based violence.
vi. Professionals should be mindful to avoid generic and formulaic plans of work and ensure the programme of work and intervention is appropriate for the

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The Designated Nurse, Safeguarding Children at CCG advised that practitioners choose which cases to take for discussion at supervision and this may or may not include cases involving CSE. The child protection supervisor may raise the issue of CSE if this is relevant.
young person, dependent on the assessed level of risk. Work should draw on the expertise the Barnardo’s workers either in direct work or via consultation. Work should also incorporate agencies who work with parent’s e.g. stronger families to offer a holistic approach in reducing the risk of CSE.

vii. Perpetrators details should be linked consistently to social care files and consideration given to linking them to school files.

viii. There should be CAMHS input to the operational group and CSE Workstream

ix. There should be consideration of CAMHS/Locala joining the HUB due to prevalence of emotional difficulties and risky sexual behaviour.

x. There is a need for more reflective supervision across all agencies, possibly joint supervision within the HUB.

xi. There is emerging evidence of indicators and apparent pre-cursors for young people being vulnerable to CSE. The contributory factors identified within this audit should inform early help provision.

xii. Closure, step down, or transfer of cases should include a transition checklist template to ensure actions are completed, perpetrators linked, views of child and family logged and triggers for future referrals made clear to aid continuity and recognition of future risk.

xiii. Information should be gathered from host authorities when young people are placed out of area and placed on Kirklees files, to ensure we are confident that young people are safe, well and supported.

xiv. Data in respect of CSE referrals and outcomes, missing episodes, missing from education and return interviews should be shared routinely with KSCB via the Evaluation and Effectiveness Workstream.

xv. Positive professional relationships should be utilised from whichever agencies engages with the young person best and a “team around the professional” approach adopted to reduce the potential for ad hoc and inconsistent service provision, or the risk of the young person disengaging due to the large number of professionals involved.