Buckinghamshire Safeguarding Children Board

Lessons learnt from serious case review

"Young Person J"

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1. DECISION TO WRITE A LESSONS LEARNT REPORT

A serious case review was commissioned by Buckinghamshire Safeguarding Children Board to review the care of "J". The review provided a detailed account and analysis of the support offered to J. As the case concerned child sexual exploitation, and J might suffer further harm if she was identified, the chair of Buckinghamshire Safeguarding Children Board requested that the serious case review should not be published in its original form. However, to ensure transparency and enable agencies to learn from the case, it was decided to publish a "lessons learnt" report.

2. BACKGROUND

J was born in the UK to British Pakistani parents. In 2012, she disclosed that she had been given drugs and alcohol, and had sexual intercourse with a number of Asian men. She said that this had been going on since she was 11 or 12 years old. She was taken into police protection and placed in local authority care whilst the police investigated the allegations.

The serious case review examined the events over a 4½ year period. Throughout this time, J continually displayed signs of distress. She persistently asserted that her father sexually abused her. She also alleged that both her mother and father hit her. However, on several occasions she retracted these accusations.

The serious case review focused on one referral to the police and a further four referrals to both police and children's social care. It sought to understand what information was known to each agency, whether this information was shared as part of those referrals, and whether the agencies' response was adequate and effective.

The following organisations provided information to the serious case review:

- Barnardos R-U-Safe?
- Buckinghamshire NHS Trust
- Children and Family Court Advisory and Support Service (CAFCASS)
- Children's Social Care – Buckinghamshire County Council
- Connexions
- GP
- Oxford Health NHS Foundation Trust
- Thames Valley Police
- Secondary school

3. LESSONS LEARNT AND RECOMMENDATIONS

3.1. Communication and information-sharing

Communication and information-sharing are common themes in serious case reviews, and this one was no exception. The lack of information-sharing between agencies had a direct impact on the care that J received. From the age of eleven, she was clearly showing signs of distress. She told every professional she came into contact with that she was not happy at home or at school. When she was not listened to, her symptoms escalated. However, there was no co-ordinated response to J's request for help so no organisation had an overview of her symptoms.

The first three strategy discussions that were held each took place over the phone between police and children's social care. There was no evidence to suggest that the appropriate partners from health or the school were involved. This meant that the two agencies that knew least about J made decisions in isolation.

If either police or children's social care had sought information from other agencies as part of these investigations they would have known that:

- The school had raised concerns about her mental health
- She was having counselling and had made allegations of historical physical assault and verbal abuse by her father to her counsellor
- She had self-harmed by cutting herself and had taken several overdoses
- She had disclosed using drugs and alcohol
- She told various professionals that she was sexually active from the age of eleven
- The GP had referred her to CAMHS
- Her attendance at school was at times around 70%
- She had been admitted to hospital with abdominal pain and the doctor who examined her suspected sexual abuse

Clearly had children's social care and police known this information, the investigation into the referrals may have been more comprehensive.

Another failure in communication and information-sharing occurred following J's disclosure of child sexual exploitation. In order to protect her and the police investigation, a non-disclosure order was granted which gave the local authority permission not to disclose to J's parents the reason why she had been taken into care or her whereabouts. However, the

purpose of the non-disclosure order was misinterpreted by some professionals who thought that the order prevented them from discussing issues with J and disclosing information to other relevant colleagues. This meant the care and support she received from agencies was limited and fragmented. Furthermore, it also prevented her parents from supporting her and meant that they were unaware of the allegations she had made.

Difficulties around communication and information-sharing were also apparent in the Complex Abuse Strategic Management Group. The group failed to ensure the co-ordinated response that was its remit. It should have been aware of the difficulties being faced by members of staff from all agencies who were supporting J – for example, the group should have ensured that all the agencies understood the provisions of the non-disclosure orders. Moreover, the group also had the potential to ensure that J's therapeutic needs were considered, ensure that members of staff were sufficiently supported, and ensure that there was good information sharing between agencies. However, there was not good communication and information sharing as some agencies were unaware of whether they were represented at the meetings at all, whilst others could not locate any minutes of meetings.

i. Recommendation One

Buckinghamshire Safeguarding Children Board should consider reviewing whether "telephone" strategy discussions between two agencies can be sufficiently robust to safeguard and protect children and young people

ii. Recommendation Two

Children's social care should assure Buckinghamshire Safeguarding Children Board that all s.47 assessments include information from all the other agencies involved with the child or young person

iii. Recommendation Three

Children's Social Care should routinely provide feedback to referring agencies about the outcome of referrals

iv. Recommendation Four

Buckinghamshire County Council Legal Services should always clarify and communicate the provisions of non-disclosure orders with children's social care, and children's social care should disseminate the information to partner agencies

v. Recommendation Five

Buckinghamshire Safeguarding Children Board should review the role and function of the Complex Abuse Strategic Management Group including:

- The link between the work of the group and operational activity
- The dissemination and storage of minutes

3.2. Giving greater credibility to retractions than allegations

The lack of communication between agencies undoubtedly led professionals to give more credence to J's retraction of the allegations rather than to the allegations themselves. As no agency had a full picture of J's life, no one appeared to look at the context of the situation or explore why she might be making allegations and then retracting them. There were times when she even told professionals that she was under pressure from her family to say she made it all up. There were other times when she was distressed by the impact that her allegations were having on her family. Again no professional appeared to appreciate the difficulties she might be having by trying to tell people about what was happening to her.

"There is significant doubt about a number of the allegations made including this one"

Head of service, children's social care

There appeared to be a degree of disbelief amongst agencies that made it easier to accept J's retractions. It was not until the allegation of child sexual exploitation that all the agencies started listening to her and even then some had doubts.

"The allegations were shocking and extreme. It raised the question that if this is true how could it have happened? There was obviously a degree of scepticism regarding the allegations, but J was described as being candid in interviews, although as time went on she could become very secretive".

Team manager, children's social care

The situation was compounded because some professionals appeared to have a degree of scepticism about the part her parents played in J's distress. Records stated that her parents always said the "right" things and gave an impression of concern. Records documented that J frequently went alone to the hospital and on several occasions no medical help was sought

following overdoses. However, health professionals did not appear to explore whether her parents knew of these occurrences. Indeed, the school did not address her attendance (around 70 - 80%). They did not formally involve the Education Welfare Service because, again, "*mother was ostensibly helpful, working in partnership with the school; she attended regular meetings and promised that J's attendance would improve. The absences were also covered by notes or emails*". Therefore, nothing was put in place to help J's parents work with the school to improve her attendance (in fact, her parents described being at a loss and feeling unsupported). On one occasion, children's social care closed the case because the parents said they were "willing to engage in family therapy" with CAMHS. They were described as being receptive to help and being concerned about her mental health needs. Then on another occasion the case was closed when both children's social care and police considered CAMHS involvement as sufficient and J's parents were viewed as "wishing to work with professionals".

Professionals did not appear to think about the implications for a girl from a Pakistani background making such allegations. J said she was worried that her parents might beat her and send her to Pakistan following her allegations. The Home Affairs Committee[1] *commented that "Asian victims* (of child sexual exploitation) *are often alienated and ostracised by their own families and by the whole community if they go public with allegations of abuse."* This also supports the findings of the Office of the Children's Commissioner that there was underreporting by ethnic minority victims of child sexual exploitation. Many South Asian victims come under pressure not to speak out about abuse. Issues of "honour and shame" play a large part, especially the "honour" of women and girls.

Recent research[2] revealed that Asian girls, who were being sexually exploited, were most vulnerable to offenders from their own communities who manipulated cultural norms to prevent them from reporting their abuse. Some of the key findings of the research included (amongst other things):

- Asian victims of sexual exploitation were being overlooked by front line agencies and little if anything was being done to identify them so they could be helped
- The majority of victims reported to the researchers were between 13 and 14 years old – the oldest was in her 30s with a learning disability
- At least a third of the victims had suffered sexual abuse when they were younger
- Blackmail connected with shame and dishonour was often used to control victims
- The offenders were frequently from the same ethnic background to the victim

[1] www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/6806.htm. Accessed online page 260 12.07.2014

[2] Shaista Gohir, Unheard Voices: The Sexual Exploitation of Asian Girls and Young Women, Muslim Women's Network UK (September 2013) – accessed online www.mwnuk.co.uk/resourcesDetail.php?id=97 10.07.2014

- Some victims were unaware of the extent or the different ways in which they had been violated or by how many men, due to drugs and alcohol

- Attitudes amongst Asian and Muslim communities are mainly dismissive or disbelieving in relation to child sexual exploitation.

vi. Recommendation Six

Buckinghamshire Safeguarding Children Board should ensure that safeguarding training includes retraction of allegations, the role of family pressure in retractions, and cultural and "language" barriers to disclosure

3.3. Victim-blaming and labelling

When the third party referral was made to children's social care which alleged that J was pregnant, it was an ideal opportunity for police and children's social care to undertake a thorough joint investigation and seek information from other agencies. This did not happen and instead children's social care undertook a single agency "investigation" into the validity of the allegations. The social worker came to the conclusion that the allegation was malicious and there was no evidence that J had been pregnant. From this point onwards J was viewed as a child who made things up.

The Cafcass individual management review commented that:

> "*The fact that J made allegations of serious abuse, had retracted previous allegations and had voluntarily returned to the abusers meant that social workers doubted the veracity of her allegations. The guardian felt that all the professionals had a lack of experience of working with young people caught up in child sexual exploitation*".

This lack of experience of working with young people caught up in child sexual exploitation was exacerbated by the fact that professionals did not regularly meet together to discuss J's case. This meant that there was not a shared understanding of her experiences. It appeared that while most agencies recognised what had happened to J, children's social care continued to doubt the reality of her experience.

Indeed, throughout her foster placement various agencies appeared to blame J for "putting herself at risk" and her foster carer. This is concerning as at the time she was in local authority care and it was children's social care that had provided her with an unsuitable

placement and, although it was away from her home town, was not perhaps significantly distant. The non-disclosure order meant that her foster carer was unaware of what had happened to J. Furthermore, despite professionals knowing that J was being sexually exploited and was potentially liable to return to her abusers, no agency appeared to give her clear instructions for seeking help out of hours. To compound the issue, neither the police nor children's social care thought to remove her mobile phone and thus prevent her contacting her abusers (or them contacting her) – even though she had openly told the police she would return to her abusers if she remained living at home.

These issues were identified in the Office of the Children's Commissioner's inquiry into child sexual exploitation in 2012. It states:

> *"Our extensive evidence shows that children who are being sexually exploited are inexorably drawn to their abusers. They may take years to escape. This can be compounded by threats to hurt family or friends if the child seeks to escape. The result is that children return repeatedly to their abusers in much the same pattern as is seen in women who are victims of domestic violence. Whilst such behaviour apparently defies logic, the evidence is that an intense emotional dependence on, and/or fear of the abusers is created. This cannot be fractured by short term restrictions on a child's liberty.*[3]

Had professionals understood more about child sexual exploitation, a second serious incident at the foster placement may have been avoided.

vii. Recommendation Seven

All professionals working with young people must attend training on child sexual exploitation. The training should equip them to understand the complex relationship between the victims and abusers, and include issues of victim-blaming and labelling

3.4. CAMHS – "the universal panacea"

It was evident from reviewing the individual management reviews that CAMHS was viewed as the answer to all J's problems. For example the genito-urinary medicine clinic did not forward concerns about J because CAMHS were involved. The counselling service alerted the school to J's allegations of physical and verbal abuse but did not inform children's social care about her sexual activity because CAMHS were involved. When J disclosed to school

[3] Briefing for the Rt Hon Michael Gove MP, Secretary of State for Education, on the emerging findings of the Office of the Children's Commissioner's Inquiry into child sexual exploitation in Gangs and Groups, with a special focus on children in care, July 2012 – accessed online on 20 May 2014

that she had an older boyfriend (23 years) and feared a forced marriage, a telephone conversation with her CAMHS worker was facilitated. The hospital never made a referral to children's social care because J was engaging with CAMHS and they thought CAMHS would have a full picture. Every agency assumed that they did not have to raise safeguarding concerns about J because CAMHS was involved. Unsurprisingly, her CAMHS workers focussed on J's mental health needs, unaware of the level of safeguarding responsibility being afforded to them.

viii. Recommendation Eight

Buckinghamshire Safeguarding Children Board should remind all agencies involved in this review that referrals should be made to children's social care whenever there are safeguarding concerns about a child or young person. Agencies must not assume that another agency will make a referral or that another agency will deal with the concerns.

4. CONCLUSION

J showed signs of significant distress throughout the years under review. She accessed a large number of services seeking help. When her symptoms are viewed together, they unmistakeably paint a picture of a child (and later a young person) who required help. Although there were clearly a number of professionals who cared about her and gave her time, space and support, there was no co-ordinated response to her needs. It is for this reason that no one had an overview of her world and the things that were going badly wrong in it.