



Children's Safeguarding Board Practitioner Briefing

Briefing Number 1: Learning lessons from a Multi-Agency Review – Sonia

What is a Multi-Agency Review?

A Multi-Agency Learning Review (MAR), is undertaken by the Safeguarding Children Board when;

- a child has been either significantly harmed or abused
- the statutory criteria to undertake a Serious Case Review has not been met but there are lessons to be learnt from the case

Professionals from a wide range of agencies working with a child and family contribute their experiences and perspectives in an effort to; learn and explore what could have been done differently to improve the outcomes for the child and to provide future guidance for professional practice.

Changes since the Multi –Agency Review for Sonia

1. The Multi-Agency Review, in relation to Sonia, had a number of recommendations for single agencies to action, which has been presented at LSCB Serious Case Review Sub-committee.
2. Within Cambridgeshire the following processes and policies are now available to help identify and to support cases such as Sonia's:
 - The joint referral form, which can be completed by any agency/professional who have a child protection concern, has a section specifically designed to note information referring to; CSE, exploitation and gangs. Additionally there is a CSE operating policy and CSE risk management tool.
 - The MET Hub (Missing Exploited and Trafficked) is part of the integrated front door which supports the identification of safeguarding risks for children/young people who go missing and who may be vulnerable to CSE. The MET ensures that all missing children have 'return home interviews' within timescales and according to guidelines.
 - Operation Makesafe meetings meet monthly and are chaired by the police to examine intelligence and provide cohorts of those children most at risk which is escalated to the MASH.
 - MASE (Missing and Sexually Exploited Meetings) chaired monthly by children's social care to look at those high risk cases or cases causing concerns in relation to CSE.
 - Community Prevention and Response Group chaired by children's social care within the Fenland area, explores safeguarding concerns surrounding central European children and young people.

The Multi-Agency Review for Sonia

Background:

Sonia was a 13 year old girl, from central Europe, living within the Fenland area with her mother and step father. She became actively involved with a 'negative' peer group who placed her at 'serious risk' of child sexual exploitation (CSE). Sonia soon became withdrawn and started to miss lessons and was absent from school (on a number of occasions) and was said to be showing signs of isolation from the Fenland community due to language barriers. There were reports, from her mother that whilst Sonia was missing she had been drinking alcohol and sleeping naked in an older boy's bed.

As a result of Sonia's difficult behaviour at home her mother said that; she used physical chastisement (using a belt) to try to set boundaries and to discipline her. Sonia reported this at school and children's social care were involved due to the physical abuse from parents and that Sonia did not want to return home. After five days in foster care Sonia was returned home, against her wishes, as her mother wanted her home. In 2016 Sonia was made the subject of a child protection plan.

In June 2016 it was recorded, on police files that; Sonia had been plied with drugs and alcohol, by a 27 year old male and then he sexually assaulted her. On health files it was noted that Sonia had tried to self-harm at home and had been physically assaulted by her parents when she told them about the sexual assault; that she had been given crystal meth by an older man and then raped.

In 2017 that sexual assault case did not proceed due to insufficient evidence and conflicting accounts from witnesses.

Learning Points and Opportunities Missed

A workshop took place with all of the agencies involved with Sonia and her family and the following points were discussed and put forward as areas to focus on for future learning to help prevent a case like this happening again:

- **Multi-agency working – lessons learned**

Participants agreed that there should have been joint intervention by police, social care earlier in the case. Throughout the case agencies involved appeared to work in 'silo's' and did not always share important information or agency decisions to protect the child.

High caseloads and the lack of availability of interpreters impacted on timings of the investigation into the assault from Sonia's mother. If this had been acted upon earlier this may have stopped Sonia from withdrawing her complaint against her mother, for the second assault matter. ,

When children / young people are reported as 'high risk' when 'missing' this must always be taken seriously and home safe and well checks initiated.

In all cases of missing children (no matter how long or short the time away from school and /or the home) CSE should be considered. Additional factors such as peer group, alcohol and potential sexual abuse should also trigger CSE risk assessments with any agency working with the child /family.

- **Education / Early Help**

Check out what a child and families circumstances may be for the reduced / non-attendance of a child at school. Remember children going missing can be a high risk indicator of CSE. Are the absences something which children social care need to know about? Is it a child protection concern?

When sending letters regarding a child's school attendance, check whether the letter needs to be translated and if the parents / carers understand what is being stated within the letter.

When Attendance Penalty Notices are paid by parent(s), check whether there is a pattern of non-attendance of the child(ren) and what the reasons were for the child not attending. Parents paying a fine addresses the punitive element of non-attendance though cases may need to be explored further to ascertain the real reason for non-attendance and to see the wider picture of any potential child abuse.

- **Court Services**

When cautioning offenders make sure that the person understands what a caution is and what it means in relation to the alleged offence and future implications surrounding criminal records. If necessary interpreters and/or language line should be considered for those people who speak different languages.

What we do know from research and cases of CSE across the UK is that children involved in CSE often are unable (threatened / coerced/ their age and understanding) to give clear witness statements and statements are often changed over time. This should not make their statements unreliable but rather observed as part of a pattern and potentially more evidence of CSE and child abuse.

- **Information sharing and record keeping**

All agencies need to share information regarding safeguarding concerns about a child. Having a complete picture/analysis of a child and families situation helps to protect the child.

Practitioners should keep up to date records of work with the child and family and all plans should be completed and kept on file. Be mindful of correctly spelling names and make sure that what is written is based on fact. Remember a child/family and/or Court can ask to see what has been written about them and professional can be held to account.

Practitioners should record all decisions regarding a case and ensure that it is signed and dated.

Discussions and outcomes, from strategy meetings, should be recorded on file for all agencies who were part of the meeting. This will show decisions regarding actions taken and any risks to the child.

- **Cultural Competence**

Agencies need to be creative and flexible when working with a community who work excessively long hours and to follow up missed calls and appointments. This should be addressed in commissioning arrangements where possible.

Do not make assumptions about how a family may react to certain circumstances. Think about what's life like for the family in question – what might a sexual assault on their child mean for them? How might they react? Will the child be at risk after they have been informed?

When families go away for holidays to their country of origin, do not make the assumption that they have left the country and will not be returning and then close the case.

Does the family and child need the support of an interpreter / is this recorded on file? If so access to one should be planned for and be available at all times when working with the child and family.

- **Professionals**

Experienced and qualified practitioners should be working with children and young people deemed to be 'high risk' of child sexual exploitation. Complex high risk cases should not be left with newly qualified and inexperienced workers.

- **Parents**

Practitioners need to consider the possibility that parents maybe offering **disguised compliance** by missing set appointments.

Professionals need to be '**professionally curious**' - find out why parents do not attend appointments ask them are they unable to attend due to work, transport or other restrictions?

Professionals also need to be '**respectfully uncertain**' and to check out what parents tell us.

Parents concerns about their child(ren) should be recorded and shared with other agencies when this relates to child protection.

- **Voice of the child**

There were missed opportunities where Sonia could have been asked or consulted regarding agency actions which may have informed professionals about how she felt and supported the identification of any further risks to her.

Agencies should have been '**professionally curious**' and Sonia could have been consulted about; strategy meetings and exit strategies for when/ if returning home and asked why she was missing school and not returning home. What was life like for Sonia?

- **Risk to the child**

Discussions need to take place between agencies concerning the potential increased risk of the abuse of a child should they be considering returning the child home whilst there is an active police investigation into alleged abuse.

Professionals need to consider all areas of risk and not just focus on one issue for the child. In this case CSE was focused upon and other risks for Sonia arguably less so.

Further Information : Safeguarding Board Websites:

<http://www.safeguardingpeterborough.org.uk/children-board/>

Safeguarding Training: <http://www.safeguardingpeterborough.org.uk/availabletraining/>