LSCB Multi-agency CSE Audit (updated May 2017)

The focus of this audit was a multi-agency review of eleven cases with six for children and young people who had been absent/gone missing and a further five cases where concerns had been raised about the risk of CSE. The panel used the current Ofsted grade descriptors as a framework for assessing the robustness of the practice and management of the cases selected and the themes identified below are therefore based on the information made available to the panel.

About the Audit

There was a three stage approach to this piece of work.

Stage one took place in 2015 was to review 11 case files starting with a paper based analysis of referral documents and related CSE prevention plans, verification of their agency involvement and identification of any areas of good practice and those requiring improvement. Attendance was also required at an inter-agency panel meeting in order to report on analysis undertaken.

Stage two (2015) involved a survey of practitioners who had worked with each of the selected children and young people.

Stage three (2017) was a consultation with the young people who were selected (as appropriate).

Findings Update (May 2017)

Prior to making contact with the young people, time was spent collating multi-agency updates to review what is known to have happened in their lives since the initial chronologies were concluded. Feedback on nine of the eleven children (between Aug 2015 – Dec 2016):

- In seven cases there were continued concerns.
- In five of these cases there were worries around potential CSE.
- These five cases were open to CSC and had disorganised family life and /or out of parental control with long term family dysfunction apparent.
- Three were misusing substances.
- Two had mental health issues with suicidal ideation.
- Two were NEET; two in work and the other in specialist school provision.
- Three had offending behaviour with gang culture in two.

What did the practitioners say?

A total of 36 responses were received from a range of services. Emerging themes included:

- Poor family relationships
- Poor behaviour (and / or truanting) at school
- Mental health and emotional well-being

Good communication and sharing of information was cited as an area of good practice but was also mentioned as an area for improvement.

The quality of engagement between the young person and their worker was considered positive along with the quality and security of LAC placements and engagement with families.

Areas perceived in need of improvement included early intervention work, awareness of early warning signs, confidence building, joint and inter-agency working and how to engage with resistant young people and parents. Single cases also identified the need to think about the whole family particularly younger siblings and addressing the impact of domestic abuse on the child or young person.

What did the young people say?

Feedback was provided by three young people; two had more complex histories.

When asked how they felt when professionals and others were concerned for them, one stated that he did not care. Another reported feeling “really annoyed and upset” as she had not wanted professionals involved. She felt they didn’t understand her relationship and so “could not speak to them and instead had to keep my feelings hidden.”

When asked what advice they would give to other young people one said “Stop where you are going mate. It doesn’t end up good. It’s just not worth it” and another “Running away does not solve your problems, you still carry them with you. So if you speak to someone instead it can make your problem go away.”

The young people gave the following advice for professionals “If you’re going to drop out a big word, break it down”. “You need to get down to their level. Talk and be nice. Be kind, like how you would speak to a brother or a sister. Let them know they are in safe hands.”

Audit Conclusions

- There was some outstanding practice identified and evidence of workers tenacity in spite of many young people's reluctance. This makes it important for workers to repeatedly attempt to engage with children and young people.
- Return Home Interviews provide important information that informs safeguarding arrangements for them and other children.
- It is not clear that risk associated with 'missing' are addressed consistently within Care Plans or whether schools are involved or aware of. The IRO should be consistently informed of the risks associated with LAC who are 'missing'/CSE and be involved in ongoing planning.
- Further work is needed in regard to recording 'missing' episodes and CSE concerns for out of area placements.
- Exclusion of pupils appeared to increase the risk of them experiencing harm and exploitation.
- It is important that the lead professional continues to plan and assess risk whilst waiting for other services to commence i.e. CAMHS, FIT
- It is important that historical information / complex issues are properly understood (and research evidence applied) when a case closure is being considered.
- The age of the young person appeared to a dominant factor in assessing vulnerability in some cases. Young people in 'legal' relationships with older adults should be the subject of thorough enquiry and assessment. It was unclear if violence and abuse within young people's relationships was fully assessed.
- Specialist assessments should be sought if workers are not confident to assess young people with disabilities who exhibit sexualised behaviour.
- It is very important that internal systems do not hinder communications across different teams and how they share information with partners.
- The 'disruption' of CSE did not appear to be owned by all partner agencies and there may be a risk of insufficient focus on alleged perpetrators.
- A comprehensive assessment should be undertaken where parenting capacity is known to be very limited.
- It is important that those that remain vulnerable to CSE as they reach 18 years of age continue to be supported.

Audit Recommendations

1. Review and update policies to ensure clarity of definitions in terminology between missing and absent by different professionals.
2. Review the use of historical information / evidence to inform judgements / assessments and link with agencies file retention policies.
3. Review the use of S47 for individual incidents on children where the risk is not always identified as multi-agency.
4. Review whether the IRO is informed of missing incidents to inform risks for LAC placed out of borough and quality of other local authorities' response to CSE.
5. Review the need to evidence research in assessments and planning.
6. Consider the issue of "age" and "consent" when young people involved in relationships with other young people and older adults.
7. Review the impact of low level fixed term exclusions on missing children.
8. Review whether agencies understand the disruption of CSE and whether this is undertaken.
9. Create a multi-agency pathway that will maximise the potential of safeguarding young adults as they reach 18 years of age.

Following on from the audit recommendations; what can we do now?

Repeatedly try to engage children even if they intially reject efforts to keep them safe.

A robust risk assessment should be undertaken regardless of the age and gender of the young person

Ensure complex issues are adequately resolved before agreeing to case closure.

Be sure your agency continues to support the child and family whilst waiting for services.