



Derby Safeguarding Children Board

Serious Case Review

BD09

Executive Summary July 2010

Agreed by Derby Safeguarding Children Board on 13 August 2010

**Author: Janet Galley
Independent Social Worker**

1 Introduction

The Serious Case Review Process

- 1.1 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires local safeguarding children boards to undertake serious case reviews in accordance with government guidance contained in Chapter 8 of Working Together to Safeguard Children. The updated version of Working Together was published in February 2010 during the course of this review and the changes to the guidance were taken into account by the Serious Case Review Panel. However, the review has been formally conducted under the 2006 guidance.
- 1.2 The purpose of a Serious Case Review (as set out in Chapter 8 of Working Together to Safeguard Children 2006, and amended, as shown *in italics*, by Working Together to Safeguard Children 2010) is to:
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work *individually* and together to safeguard and promote the welfare of children;
 - Identify clearly what those lessons are *both within and* between agencies, how *and within what timescales* they will be acted upon, and what is expected to change as a result; and
 - Improve *intra- and* inter-agency working and better safeguard and promote the welfare of children.
- 1.3 In this case Andrew Flack, (then) Director of Children's Services, the then chair of the Derby Safeguarding Children Board (DSCB) made a decision to undertake a serious case review on 10 June 2009 in relation to two females, known as YP1 and YP2, on the grounds that:
- They had been subject to serious abuse;
 - They were abused while being looked after by the local authority;
 - There were lessons to be learned in relation to the investigation of serious and complex cases and in the early identification of, and effective early intervention in cases such as this, and;
 - The case has implications for a range of agencies and professionals.

Circumstances that led to a Serious Case Review being undertaken

- 1.4 Concerns were identified in 2008 about young people in Derby who were being sexually exploited. The Police set up an investigation into Child Sexual

Exploitation and Trafficking within the UK, and involved a number of other agencies who are Derby Safeguarding Children Board (DSCB) partners. This was a complex and ground breaking investigation, which led to the successful arrest and prosecution of alleged perpetrators. Once concerns were identified, agencies worked well together to identify and support victims. Questions emerged about the background and history of the young women, and whether anything could have been done to prevent them being abused at an earlier stage. This serious case review addresses these questions in relation to two young women, YP1 and YP2, who were also looked after by Derby City Council.

- 1.5 In addition to YP1 and YP2 25 more young people living in the community were identified as having been abused in similar ways. Although their circumstances were judged not to meet the criteria for a serious case review Derby Safeguarding Children Board recognised that the experiences of these young people were equally important, and an internal process of multi-agency reviews (MAR) was undertaken in respect of these young people. The lessons arising from these reviews are incorporated into the serious case review, and the recommendations arising.
- 1.6 The combination of the serious case review and the MARs has made this an unusual and particularly complex review. Other unusual features have been the consideration of issues in relation to the alleged perpetrators, and the pivotal role played by a voluntary organisation, Safe and Sound Derby, in identifying and addressing the nature and scale of the abuse.

Organisations involved in the Serious Case Review

- 1.7 The following organisations completed Individual Management Reviews (IMRs) for both YP1 and YP2:
 - Derby City Council Children and Young People Directorate (Children's Social Care);
 - Derbyshire Constabulary;
 - NHS Derby City;
 - Derby Hospitals NHS Foundation Trust;
 - Derbyshire Mental Health Services NHS Trust;
 - Safe & Sound Derby, a local voluntary organisation (Barnardo's were commissioned to write the Individual Management Reviews);
 - Derby City Council Children and Young People Directorate (Social Development and Inclusion Service, drawing upon information from individual schools as appropriate);

- Derby Youth Offending Service.
- 1.8 Derby Youth Service (Young Runaways Service) were involved in providing services solely for YP1 and provided an Individual Management Review in respect of this young person. No services were provided for YP2 and no additional lessons emerged indicating that a separate Individual Management Review was required.
- 1.9 Connexions Derbyshire Ltd had limited involvement providing services solely for YP1 and provided an Individual Management Review to capture the learning arising from their analysis of the services to her. No services were provided for YP2 and no additional lessons emerged indicating that a separate Individual Management Review was required.
- 1.10 A serious case review panel was established with the following membership:
- Independent Chair;
 - Derby Safeguarding Children Board Policy Officer;
 - Head of Children and Adults legal services, Derby City Council;
 - Service Director of Specialist Services, Children, Derby City Council;
 - Head of Quality Assurance, Children's Services, Derby City Council;
 - Head of Youth Offending Services, Derby Community Safety Partnership;
 - Detective Chief Inspector, Public Protection Unit, Derbyshire Constabulary;
 - Deputy Director of Nursing and Head of Patient Safety, Derbyshire Mental Health Services NHS Trust;
 - Designated Nurse, NHS Derby City Community Health Services;
 - Designated Doctor, NHS Derby City Community Health Services;
 - Chief Executive Officer, Safe & Sound Derby.
- 1.11 Due to the complex nature of the case a number of safeguarding professionals within the health service were involved operationally. To ensure independent scrutiny a designated nurse from a neighbouring city has attended the panel in an advisory capacity.
- 1.12 A similar situation existed within the police force, and therefore a

representative new in post, with no prior involvement in the case, has attended the panel to provide a measure of independent scrutiny.

- 1.13 The Derby Safeguarding Children Board appointed Sue Gregory as independent chair. She has significant background experience in dealing with the specific issues arising from this serious case review. Janet Galley was appointed as independent author of the serious case review. She is an independent social worker with considerable experience as a practitioner, manager and inspector of children's services. Until April 2010 the chair of Derby Safeguarding Children Board was Andrew Flack, the Director of Children's Services for Derby City. From May 2010 until August 2010 when this review was completed, the chair was Ros Vahey, new Director of Children's Services for Derby City.
- 1.14 In parallel with the serious case review, the following internal agency reviews have been undertaken, and the findings incorporated into the individual management reviews for this serious case review:
 - Derbyshire Constabulary;
 - Probation Service;
 - Safe & Sound Derby;
 - Youth Offending Service.
- 1.15 There are ongoing criminal proceedings in this case and negotiations have taken place with the police and Crown Prosecution Service to ensure they are not compromised by the serious case review process. This executive summary will be made public when the criminal proceedings are completed.
- 1.16 YP1 and YP2, and family member(s), have been interviewed for this serious case review, and their views and experiences incorporated into the lessons and recommendations.

2 Summary of Events

- 2.1 The two young people were known to agencies, and there had been concerns about their welfare over a number of years. However despite these concerns they were seriously abused both before, and subsequent to being looked after by the local authority. Individual agencies had sought to offer specific support, but did not recognise the signs and symptoms of abuse evident in the behaviour of both young women and information was not shared effectively. Therefore the full picture of the young women's circumstances was not understood.
- 2.2 The early life experiences of YP1 and YP2 were the underlying reasons for their later vulnerability to abuse as adolescents. They both experienced, in different ways, inconsistent parenting, neglect, significant losses and

isolation. Universal services – health and education – missed early signs of concern, and children's social care failed to respond consistently when concerns were raised. Opportunities were missed to intervene in their early lives to address these concerns effectively. Had this been done it is likely that they would have been more resilient, and therefore less vulnerable as adolescents to all kinds of exploitation and abuse, including the abuse they did experience.

- 2.3 On reaching adolescence their behaviour became increasingly chaotic and risky. The risk of 'significant harm' was clear from 2008 onwards. Again there were missed opportunities to intervene specifically to address these concerns, and to use existing safeguarding procedures to protect them. The levels of risk were either not recognised, or inaccurately assessed. There was little evidence of concerted inter-agency action, and no application of existing procedures, such as the Common Assessment Framework (CAF), for collating information and concerns.
- 2.4 A number of agencies were involved, and worked hard within their own sphere to help YP1 and YP2. There is however little evidence of agencies working together to co-ordinate actions and create a comprehensive picture of the lives of these two young women. Statutory agencies on the whole did not recognise, or understand, the signs and symptoms of the abuse being suffered by YP1 and YP2, and how to respond. There were gaps in communication between agencies, so no one had a complete picture of the circumstances of YP1 and YP2.
- 2.5 Both YP1 and YP2 were looked after by Derby City Council under section 20 of the Children Act 1989, YP1 from April 2009 and YP2 from October 2008. YP2 had previously been subject to care proceedings in 2006, and her paternal grandmother was granted a residence order in July 2006. Their behaviour by this time was extreme, and the facilities and resources available to Derby City were not sufficient to prevent their continuing abuse. Placement choice was limited, and staff were unable to prevent their frequent absconding, or to manage their challenging behaviour. Staff did not recognise the significance of their behaviour in terms of abuse, and they were dealt with as 'rebellious adolescents'. There were critical delays in making provision for out of city placements, which for YP2 meant she was convicted of assaulting care staff in the intervening period and received a custodial sentence. Both YP1 and YP2 received criminal convictions for behaviour that should have been dealt with in terms of their status as victims of abuse, rather than as offenders.
- 2.6 A police operation was set up in January 2009, to identify and apprehend abusers. It was innovative and ground breaking, and used covert surveillance to obtain evidence. This led to successful arrests and prosecutions. It is clear that it did not fit well with the current Derby Safeguarding Children Board procedures, which assume the starting point as safeguarding concerns about young people, and not, as was the case here, the focus on perpetrators. This review has identified aspects of the operation which could have improved inter-agency working. These can be summarised as – a clear understanding of the roles and responsibilities of all agencies and the involvement of all relevant agencies at the earliest possible stage, an

agreed approach to assessing risk and abuse; a consideration of the resources needed, and an agreed process for information sharing across agencies. Notwithstanding these drawbacks, once the level and nature of the abuse had been recognised when the police operation went ‘live’ in April 2009, the response from all agencies was commendable. They worked well together to address the needs of the victims, and support their staff. This is noted below as an example of good practice, and of what can be achieved when agencies adopt a joint approach to achieving a common goal.

3 Key Issues

3.1 The key issues to be addressed by the serious case review were:

- Identification of needs and indicators of abuse – were practitioners sensitive to the needs of the young person and knowledgeable about indicators of abuse;
- Organisation policies and procedures – did organisations have policies and procedures in place for safeguarding and promoting the welfare of children, and were these known and implemented. Were the Derby Safeguarding Children Board inter-agency procedures known about, and used effectively;
- Assessment – what were the opportunities for assessment. Were assessments and decisions conducted in an informed and professional way. How well did they include all relevant agencies and the family and young person. Did they effectively assess the risk of abuse;
- Taking action to safeguard the young person – did actions accord with assessments and decisions. Were appropriate services offered and/or provided;
- Effective planning – were appropriate child protection or care plans in place, and reviewing processes complied with;
- Organisational issues – were senior managers involved; how well were services co-ordinated; were there resource issues which impacted on the case;
- Issues of identity – was practice sensitive to the racial, cultural, linguistic and religious identity of the young person and their family; how did issues of identity impact on the abuse of the young person;
- Young Person’s wishes and feelings – when, and in what way, were these understood and taken into account.

3.2 Similar key issues were identified for consideration in the multi-agency reviews.

- 3.3 The main findings in relation to these issues are summarised as follows:
- 3.4 Concerns about the welfare of YP1 and YP2 emerged at an early stage; for YP2 from birth; for YP1 from primary school age. The seriousness of the concerns and impact on the two children was not recognised by health and education services, and when referrals were made to children's social care opportunities were missed to undertake a comprehensive assessment of their needs. From 2006 concerns increased, and from 2008 they were both engaging in very disturbed and risky behaviours. These included criminal activity, absconding, drug and alcohol misuse. Practitioners in health and education and in children's social care failed to recognise the significance of these behaviours in terms of abuse, and to intervene effectively. Had the needs of these two young people been better identified and addressed at an early stage, the risks of later abuse might have been reduced.
- 3.5 Agencies had relevant policies and procedures in place but staff were not always aware of them, and/or did not use them in a timely way. Child protection procedures were not well understood by staff in universal services, and children's social care staff did not apply them on every occasion when the level of concern clearly demanded it. Health and other professionals were not always familiar with policies in relation to information sharing, and therefore information about concerns was not shared effectively. Some agencies used their own procedures appropriately, for example schools when seeking to address the disruptive behaviours of YP1 and YP2, and police when dealing with missing person episodes, but they were used in isolation, and did not contribute to a comprehensive picture of the young girls' needs.
- 3.6 The Derby Safeguarding Children Board had procedures in place to deal with complex abuse, which were used to inform the police investigation. However, they were not well understood by managers and staff, they did not fit well with the requirements of this investigation, and were not therefore comprehensively applied. This led to some difficulties in relation to information sharing, resource allocation, risk assessment and clarifying roles and responsibilities.
- 3.7 Both YP1 and YP2 were subject to many assessments; most related to specific behaviours, issues or events, and included assessments of educational ability, criminal behaviour, mental health and wellbeing, general health and development and work and employment. There were missed opportunities to conduct a comprehensive assessment of their needs, including a risk assessment. Only latterly, following the police operation, were concerns brought together to form a comprehensive assessment.
- 3.8 In the absence of a comprehensive assessment, assessments in relation to sexual exploitation did not fully take into account the vulnerabilities of YP1 and YP2 when considering their capacity to consent to the abusive activities, and their ability to make an informed decision about whether or not they wished to be involved with their abusers.
- 3.9 Plans to intervene to safeguard YP1 and YP2 were hampered by the absence of good assessments, and once they became looked after it quickly became clear that facilities in Derby were inadequate to deal with their behaviour. Plans were made to pursue alternative placements outside

Derby, but there were avoidable delays in implementing these plans. This resulted in YP2 receiving a criminal conviction for assaulting care staff, for which she received a custodial sentence. YP1's behaviour escalated out of control and she was placed in secure accommodation for her own protection.

- 3.10 Both young women were subject to a number of plans, for example looked after children plans, child protection plans, youth offending plans, but it was not always clear which plan took precedence, and how information was shared between agencies to integrate the plans. For example, both young women were convicted of offences. Whilst youth offending plans took account of the risks of abuse, there was little understanding of the links between the offending behaviour and the impact of sexual exploitation, and poor communication between the Youth Offending Service and children's social care meant that not all the risks were known. YP1 and YP2 were dealt with as offenders, rather than as victims of abuse.
- 3.11 Organisations were ill prepared for the scale and complexity of the abuse exposed by the police investigation. Not all senior managers from relevant agencies were involved at an early stage, and information was not shared with the Derby Safeguarding Children Board until after the operation had gone 'live'. The investigation would have benefited from the earlier involvement of senior managers from all the agencies who were later involved when the operation went live. In particular, they needed to consider the additional resources required and to agree a contingency plan, and victim support plan. The absence of these plans impacted on the efficiency of the immediate response to the disclosures, although agencies now have these in place.
- 3.12 Information sharing and inter-agency communication has been identified by this review as a key issue for all agencies. Some services were unfamiliar with the principles underpinning information sharing when there are safeguarding concerns, and some services were unwilling to share information when there was clearly a safeguarding concern. At other times agencies did not recognise the significance of information held by them, and therefore did not share it. There was confusion about what information could be shared about the police investigation, which led to misunderstandings and misperceptions. Overall the failure to share information and communicate effectively had a significant impact on the understanding of the circumstances of YP1 and YP2, and the ability of agencies to respond effectively.
- 3.13 Issues of culture, ethnicity and identity were a feature both in relation to the victims and the alleged perpetrators. YP1 and YP2 were confused about their identity and sense of belonging. They both had a poor self image and had difficulty making friends and fitting in. In one assessment of YP2 there was a recommendation that she should be offered help to address this, but there is no evidence that this was done. None of the assessments of YP1 and YP2 paid any detailed attention to this aspect of their lives. However it was a critical factor in making them easy targets for abusers. Questions have been raised for this review as to whether the ethnic background and culture of the perpetrators had any bearing on their decision to take part in this activity, and also whether the ethnic origin of the victims was significant in making them targets for abuse. It has not been possible to draw any firm

conclusions from this one review, but it is worthy of wider consideration, possibly on a national basis.

- 3.14 There was little evidence of YP1 or YP2 being actively involved in discussions, assessments and plans in the early years. As adolescents there is evidence that practitioners sought to involve them in plans for their future, but assumptions were made about their ability to make choices, and to make decisions about their lifestyle. There is a balance to be struck between the need to consider the wishes and feelings of the young person when planning for their care as looked after children, and the requirement to protect them from harm. With hindsight more prompt and decisive action should have been taken by children's social care to protect them from harm.

A combination of factors resulted in neither YP1 nor YP2 being able to talk about what was happening to them. These included their own behaviours and unwillingness to engage with services; the fact that they did not initially see themselves as victims of abuse, and the power of the abusers to silence their victims; together with a general lack of understanding on the part of agencies of the signs and symptoms of sexual exploitation; the perception of YP1 and YP2 as rebellious adolescents; the fragmentation and limitation of some services, notably residential care services and the assumption that they were going 'willingly' with their abusers. Once they were given the opportunity to talk, they were able to express their views about the abuse, and begin the process of being helped to overcome their experiences.

4 Priorities for learning and change

- 4.1 The fundamental lesson from this review is that the potential for poor outcomes increases significantly when intervention does not take place at an early stage to address early signs of concern. This is not a new lesson, but it has over the years been a difficult lesson for agencies to put into practice. The cost both to individual children in terms of their emotional and psychological well being, and to the country in terms of resources, is far greater when this does not happen, as evident in this serious case review.
- 4.2 In seeking to answer the question of whether the abuse was predictable and preventable, it is difficult to conclude that the particular abuse of sexual exploitation was predictable. However, given their backgrounds and early experiences it was predictable that YP1 and YP2 would become vulnerable adolescents and therefore at greater risk of some kind of abuse. Had there been earlier, concerted intervention in their lives to address their unmet needs it is likely that they would have been less vulnerable as adolescents and therefore less likely to be abused.
- 4.3 These conclusions are mirrored in the findings from the multi-agency reviews. There were missed opportunities to assess significant concerns in relation to the other young women and comprehensive assessments were not completed. There was little evidence of the use of the Common Assessment Framework (CAF). When they were completed, the quality of assessments was frequently poor, with little involvement of the young person and their family, and all the relevant agencies. There was a correlation between those

young women who had the most complex needs arising from their childhood experiences and those who were least willing to engage with services to help safeguard them. The missed opportunities to address these needs early in their lives have had a longer term impact on their isolation from sources of support. Safeguarding procedures were not used early enough when there were clear signs that they were at risk of suffering significant harm, and delayed effective action. In particular there was a failure to understand the impact of coercion by the abusers on their behaviour, and to assess their capacity to make informed choices about whether or not they were truly consenting to go with their abusers.

- 4.2 A number of specific learning points have been identified, as follows:

Identifying Needs and Indicators of Abuse

- 4.3 Early childhood experiences have a critical impact on later development, and need to be thoroughly assessed and understood, both at the time, and in retrospect if intervention begins at a later date.
- 4.4 More work is needed to understand the significance, if any, of culture and ethnicity in contributing to both perpetrator and victim profiles.
- 4.5 Early intervention to address known concerns is the most effective way of preventing later problems, and services need to focus time, attention and resources on this area of work.
- 4.6 A parent's own history and lifestyle has a significant impact on parenting abilities, and this needs to be assessed and understood.

Policies and Procedures to Safeguard Young People

- 4.7 There are well established links between young people who go missing and the risks of child sexual exploitation (CSE). Any revised system for identifying these risks must ensure that the messages are disseminated to front line practitioners and incorporated into updated training and procedures.
- 4.8 Policies and procedures were generally in place and adequate. Staff were not always aware of them, and/or did not use them in a timely way.
- 4.9 Written records are an essential requirement of good case management in all agencies and must be completed and kept up to date.
- 4.10 The Derby Safeguarding Children Board Complex Abuse procedures did not work well and were not well understood by managers and there was a belief by those involved that they were not fit for purpose.

Assessments

- 4.11 Early assessment of the vulnerabilities of a young person using the Common Assessment Framework (CAF) must be improved, particularly in schools and health services.

- 4.12 Assessments of risk of child sexual exploitation (CSE) must include consideration of issues of 'capacity' and 'consent', within the context of the young person's current circumstances, and previous history, and the fact that child sexual exploitation (CSE) is, in itself, abusive. How the balance of risk between 'protection' and 'prosecution' has been assessed must be explicitly recorded.
- 4.13 The implications of using covert policing techniques to obtain evidence were not fully understood by all agencies, and are not covered in current inter-agency procedures. This was particularly pertinent to information sharing and assessing the actual level of risk and abuse.
- 4.14 Agency-specific assessments relating to particular behaviours and circumstances are no substitute for a comprehensive assessment of a child's circumstances, and need to be used to support such an assessment.
- 4.15 Young people considered to be at risk of child sexual exploitation (CSE) must be treated as 'children at risk' and statutory safeguarding procedures used to assess this risk and determine levels of intervention.

Planning and Intervention to Safeguard YP1 and YP2

- 4.16 Repeat use of strategy meetings can delay decision making about risk of harm and future action.
- 4.17 Criminal behaviour can be another indicator of abuse, and this needs to be taken into account when assessments, plans and sentencing options are being considered.
- 4.18 Plans for looked after children must be based on a comprehensive and realistic assessment of their needs, and the availability of resources to meet these needs.
- 4.19 Much more work is needed to determine the way in which the balance between gaining evidence and safeguarding young people is decided, and how the issue of 'capacity' and 'consent' is assessed in child sexual exploitation cases.
- 4.20 A comprehensive multi-agency contingency plan is essential for such an operation, setting out all possible risks and contingencies, and exploring the best way of deploying scarce resources across agencies to the benefit of young people.

Organisational Issues

- 4.21 Involvement of senior managers from all relevant agencies is essential at the earliest opportunity, preferably co-ordinated via the local safeguarding children board to ensure a multi-agency approach.
- 4.22 Good staff supervision and professional support is essential in enabling practitioners to deal with complex and difficult safeguarding issues.
- 4.23 Agencies are not clear about responsibilities for sharing information when there are safeguarding concerns, and this is an important issue for

clarification in general, and specifically in relation to any further police investigation of this kind.

- 4.24 A shared understanding of the principles around ‘need to know’ and the difference between information to safeguard young people and information for police surveillance operations is crucial if further operations are to succeed in terms of both safeguarding young people and apprehending perpetrators.
- 4.25 The level of resource needed for this type of operation, and the capacity of the various agencies to respond, must be considered prior to the operation commencing, to ensure its realistic implementation.
- 4.26 Staff in all agencies need to be better trained and equipped to deal with child sexual exploitation (CSE).
- 4.27 Roles and responsibilities of all agencies involved in child sexual exploitation (CSE) must be clearly set out and understood, in particular between voluntary organisations and statutory agencies.

Identity

- 4.28 Issues of identity and how they might affect young people are poorly understood by staff in all agencies. All staff would benefit from training and development opportunities to better understand how to work with identity formation and positive self image development.
- 4.29 Poor self image is a significant vulnerability factor in young people at risk of child sexual exploitation (CSE).

Wishes and Feelings of YP1 and YP2

- 4.30 A shared understanding of the grooming process and its impact on young people is fundamental for any future operation of this kind.
- 4.31 When young people are listened to, and their experiences accepted and understood, they may open up and talk about what has happened to them.
- 4.32 Patience, empathy and perseverance are needed by staff to establish successful engagement with young people.

Good Practice Examples

- 4.33 Despite these findings, agencies demonstrated a high level of commitment and co-operation once the concerns were recognised and accepted as a result of the police investigation. Examples of good practice have emerged from this process, as follows:
 - Building on the work of Safe and Sound Derby the police have developed an information system to enable agencies to share information about concerns regarding sexual exploitation with the police in a way which can be easily analysed and used. This has since been adopted by other police forces across the country.

- A multi-agency group of practitioners has been set up, and is working very effectively to support other victims of similar abuse and exploitation. It has used research evidence about the needs of victims to inform its work. The approach includes physical, psychological, social and emotional assessments, plus immediate and ongoing assessments of risk, witness protection measures, support for the family and an identified key worker. It also includes consideration of staff support, and any resourcing issues.
- Despite the difficulties identified in this report, once the police operation went 'live' the response from individual professionals and their managers was commendable. All agencies were faced with significantly increased levels of work, for which resources had not been planned. In Children's Social Care for example 90 additional strategy meetings were held in the two month period from April to June 2009. It is an outstanding example of what can be achieved when all agencies are committed to a common goal, and are working co-operatively together, and should be highlighted by the Derby Safeguarding Children Board for attention of all agencies.
- In addition to the resources that were needed to carry out the serious case review, the Derby Safeguarding Children Board agreed to the examination of the experiences of the other young women who were also abused. This became the multi-agency review (MAR) process. This has made an important contribution to the learning arising from this serious case review, and about this area of work.

5 Recommendations and Action Plan

- 5.1 There are a number of recommendations for individual agencies arising from the individual management reviews. These include recommendations made by the Major Incident Review Team for Derbyshire Police, and the Serious Incident Review conducted by the Youth Justice Board in respect of the Youth Offending Team. Agency recommendations overall include a range of staff training requirements; reinforcing current procedures where relevant; reviews of recording and record keeping procedures; improved assessment processes and better communication and information sharing systems. There are recommendations about reviewing particular services, for example the school nursing service. The complete set of recommendations and action plans from individual agencies are attached at Appendix 4.
- 5.2 In addition the following recommendations arising from the overview report are for the attention of the Derby Safeguarding Children Board and the Children's Trust. They have been linked, wherever possible, to the recommendations arising from the Multi-agency Reviews. Because of the complexity of this review, there are more recommendations than would normally be expected. The full Derby Safeguarding Children Board Action Plan is included at Appendix 4.

- Derby Safeguarding Children Board procedures in relation to complex abuse should be revised and updated to take account of the learning from this review.
- A staff development and training programme across all agencies should accompany the launch of any new procedures to ensure staff are knowledgeable about the signs and symptoms of the abuse suffered by YP1 and YP2 and know how to respond.
- The Derby Safeguarding Children Board should establish regular audit processes to ensure section 47 enquiries and core assessments are being used when there is reasonable cause to believe a young person is at risk of, or suffering significant harm, and that the purpose of, and arrangements for, strategy discussions are clarified.
- Children's Social Care should ensure that core assessments to assess risk in cases of suspected abuse of the type suffered by YP1 and YP2 include an assessment of the young person's capacity to make decisions about willingness and consent, within the context of their life experiences and circumstances, and taking account of the grooming process and the impact of coercion. Staff training should be provided to facilitate this.
- The quality of core assessments, including the involvement of children and young people to ascertain their wishes and feelings should be audited by Children's Social Care, and staff training and development provided where necessary to improve the quality.
- Service level agreements for Safe & Sound Derby, and all other voluntary organisations working with children, should set out clearly the roles, responsibilities and expectations of such agencies, and that they should in particular be able to demonstrate their adherence to Derby Safeguarding Children Board policies and procedures.
- The Children's Trust should review the early intervention and prevention strategy to ensure it is robust, and that all agencies understand the importance of early assessment and intervention to prevent later, more serious, problems arising. In particular, universal services should be reminded and helped to use the Common Assessment Framework (CAF) to complete early assessments of a child's vulnerabilities.
- All Derby Safeguarding Children Board and single agency staff training on abuse should include consideration of issues of identity and how they relate to child safeguarding, so that they inform assessments of children's needs, and how services will meet these needs.

- The chair of Derby Safeguarding Children Board should consider recommending to the Home Office that research should be commissioned into the characteristics of known perpetrators of abuse of this kind to determine whether there are any common features which might assist early identification.
- The Derby Safeguarding Children Board should remind all agencies of local and national guidance on information sharing and safeguarding children, and there should be regular staff audits to ensure these are understood and used.
- The Derby Safeguarding Children Board should ensure that the revision and implementation of the Missing Children protocol includes robust arrangements to ensure that practitioners and police officers are clear about what action should be taken when a child is reported missing, including when to share and obtain information about missing episodes, and who is responsible for analysing repeat episodes.
- The Crown Prosecution Service should ensure that issues of abuse are explicitly considered in decisions to prosecute an alleged offender who has been subject to coercion and abuse so that wherever possible young people who are being exploited are not criminalised.
- The Derby Safeguarding Children Board should ensure that staff supervision arrangements are able to provide practitioners with the opportunity to:
 - evaluate and reflect on the effectiveness of the action being taken in complex cases to safeguard the child in the short, medium and long term, and
 - resolve professional differences of opinion that impede safeguarding arrangements.

5.3 The meetings with YP1 and YP2 and family members identified the need for better and clearer information for young people and their families, which are reflected in the following recommendations, which also feature in the multi agency reviews:

- the Children's Trust should ensure that pupils receive sessions in schools to safeguard them in the digital world (e safety) and from sexual exploitation so that they are able to take action to keep themselves safe from abuse and exploitation;
- the Derby Safeguarding Children Board should provide information for families to help them understand risk factors and the impact of abuse and exploitation on the young person and the family in order to promote action that can be taken within the family to help the young person exit and recover as soon as

possible;

- the police and partner agencies should establish the use of witness care programmes that ensure that investigations of abuse and exploitation promote the best outcomes for the young person.

5.4 The Derby Safeguarding Children Board has agreed to the above recommendations and has drawn up a multi agency action plan, which sets out the timeframes within which the actions will be taken. This is attached at Appendix 4.

The Derby Safeguarding Children Board Serious Case Review Panel (a standing subgroup which meets on a quarterly basis) will ensure that the recommendations and actions for both the Derby Safeguarding Children Board and individual agencies are implemented, monitored and evaluated. Regular reports on progress will be made to the Derby Safeguarding Children Board and any delay will be brought explicitly to the attention of the Derby Safeguarding Children Board, for follow up with agencies if necessary.

5.5 Actions already taken

Agencies have been highly committed to learn the lessons from this case, and have already taken a number of actions to address the issues arising in this review, and in the multi-agency reviews. These are summarised as follows:

5.6 Joint Action

- Improvements have been made to the way in which Safe & Sound Derby and the Young Runaways Project assess cases, and closer working arrangements have been agreed so that it is clear who is working with the individual young person.
- A Joint Working Protocol was agreed in April 2010 between the Youth Offending Service and Children's Social Care to improve communication and information sharing.
- New information sharing tools are being introduced to enable information from a range of agencies about victims and perpetrators of abuse to be captured and collated in a way which can be quickly coded and analysed by police on their intelligence system. This will assist police decision making and improve links with other agencies. Safe & Sound Derby staff have been trained and the training is being cascaded to staff in other agencies in Derby.
- Derby Safeguarding Children Board has agreed plans to develop a multi-agency strategy to address the gaps in procedures identified in this review and a sub group has been formed to take this forward.

- An independent chair for Derby Safeguarding Children Board has been appointed to avoid any potential conflicts of interest in the future.
- A practitioner group is now in place, as described above, to support other young people who have been identified by the police operation as victims of abuse of this type.

5.7 Safe and Sound Derby

- Safe & Sound Derby has updated its safeguarding procedures and in July 2010 introduced trials of a computerised case file recording system.
- An escalation policy was agreed by the Board of Trustees in June 2010 and will be cascaded to managers and staff.
- Staff are undertaking training to enhance their knowledge and understanding of some of the cultural issues that may affect children and young people, including issues of disability.

They have selected a partner agency specialising in working with learning difficulties and are trialling integrated practice.

- Safe & Sound Derby is delivering awareness raising training to groups of practitioners working with children and young people in Derby.

Since September 2009 they have trained over 900 people. In July 2010, they delivered 11 training events.

5.8 Police

- New ways have been developed to analyse the frequency of enquiries about alleged perpetrators by other police forces in order that they can be followed up to ascertain whether any action is required.
- A public protection website was developed in July 2010 with 24 hour access and a dedicated analyst post was secured for the Public Protection Unit with effect from April 2010.
- All Public Protection Unit supervisors were briefed in July 2010 about the referral processes to Children's Social Care, and the joint interviewing procedures, to ensure compliance, and staff in the Child Abuse Investigation Unit were briefed in February 2010 about the escalation policy when there are concerns about a young person which have not been followed up.
- A risk assessment module was developed in April 2010 for Public Protection referrals to determine whether a referral is rated high, medium or low risk.
- Management processes were changed in January 2010 regarding the

number of occasions a person has been previously reported missing in order that repeat episodes can be identified and analysed at an early stage. Full implementation is expected by end March 2011.

- Awareness raising activity about the abuse suffered by YP1 and YP2, and the response by the police in apprehending abusers, has included staff briefings, articles and presentations to national police conferences. This is ongoing in 2010/2011 courses.

5.9 Derby Hospitals NHS Foundation Trust

- Derby Hospitals NHS Foundation Trust is reviewing the way records are kept to ensure that adult risk factors are assessed in relation to parenting capacity. Changes were agreed in May 2010.
- A new procedure has been developed which requires all hospital staff to contact Children's Social Care to ascertain any history of involvement or concerns when any child is admitted with self harming behaviour. Training is planned for September 2010 to ensure all staff are familiar with this requirement.

5.10 Community Health Services Derby

- There is now a shared record in place for child and family teams, children in care teams and community paediatricians.
- A task-and-finish group was set up in August 2010 to address the single child health record issue across the whole children's community health service. This is due to complete by December 2010.
- Information sharing across health agencies was identified as an issue in a previous serious case review in 2009 and a new template was developed in September 2009 and implemented in May 2010 to facilitate this.
- As an early stage of the review of the school nursing service (ref recommendation 8.1), it was agreed in August 2010 that the specification for the service will be amended to clarify that it covers all school aged children and not only those that are attending school.

5.11 Derbyshire Mental Health Services NHS Trust

- Processes for referrals to Child and Adolescent Mental Health Services (CAMHS) were reviewed in October 2009 and also how the service responds to non attendance (DNA's), following lessons from both this, and a previous review.

5.12 Children's Social Care

- The learning from this review is already being disseminated to managers from May 2010 onwards, through staff meetings and workshops.
- An initial service review has been completed, published in April 2010, and has included children's residential care services. A more comprehensive review of current provision will examine whether it is fit for purpose, and if not, what action needs to be taken.
- It has been acknowledged that there is a gap in the written policies and procedures in relation to the decision making process prior to making an application for a secure order on welfare grounds. Initial discussions have taken place between Children's Social Care and legal services to prepare a written policy by December 2010.

5.13 Education Service

- Checks were made on Safeguarding training and all KS3&4 (Key Stages 3 and 4) Pupil Referral Units had Level 1 Safeguarding Awareness Training in July 2010, topped up with a Safe & Sound Derby training session specifically on the kind of abuse experienced by YP1 and YP2.

5.14 Youth Offending Service

- Revised guidance for assessing and managing vulnerability was developed in November 2009 and disseminated to all staff in February and July 2010. This includes a vulnerability risk register to assist the management oversight.
- All practitioners and a number of volunteers have attended specific training on the issues of abuse identified in this review.

50 individuals in total have been trained throughout June and July 2010.

5.15 Connexions Derbyshire Ltd

- Since May 2010, team leaders are now specifically required to identify vulnerable young people and ensure that appropriate support is provided.
- Liaison arrangements with schools were reviewed in July 2010 to ensure they are effective in identifying such young people.

6 Evaluation by Ofsted (Office for Standards in Education, Children's Services and Skills)

The serious case review has been evaluated by Ofsted who judged it to be

Signed

Ros Vahey, Chair of Derby Safeguarding Children Board

Signed

Sue Gregory, Independent Chair of the serious case review panel

Date