SANDWELL SAFEGUARDING CHILDREN'S BOARD

7 Minute Briefing – Child Sexual Exploitation (CSE) and Missing Multi-Agency Audit

01 – Aim of Audit:

To evaluate how effective the multi-agency response is to cases where Child Sexual Exploitation (CSE) and Missing concerns have been identified. With an overall aim to assure that the quality of the response to the risks of CSE and/or children going missing from home and/or education are understood and responded to by all partner agencies.
A sample of 10 cases were obtained from the CSE Co-Ordinator based at Sandwell MASH, 5 cases were chosen with concerns of CSE, and 5 with 3 or more Missing episodes. The sample for CSE was 4 girls and 1 boy, and was a mixture of involvement including Targeted Services, Child in Need, Child Protection Plan, and Looked after Children. The sample for Missing was all boys and was a mixture of involvement including from Children's Trust (CP/CIN/LAC).

02 - Learning from CSE cases:

•Current CSE assessment tool needs to be adapted to consider the significant risk of emotional harm posed by on-line sexual exploitation.

•Conversations need to be had with parents as to the lasting impact of domestic abuse on children and young people and structured interventions are needed to help repair child/parent relationships following the abusive relationship(s).

•Evidence of non-compliance and/or disguised compliance by families. Increased assertiveness from practitioners in actively intervening and talking to parents about disguised compliance is needed, challenging the evasion of meetings/visits and contact practitioners.

•Where the young person was actively engaged with the multi-agency process, the outcomes and reduction in risk was greater

•Contribution from Adult services will assist when examining the history of the case and challenging parent's behaviour/ensuring that they are engaging in services.

07 – Recommendations for Seniors/Managers:

1. To ensure that information is provided for the multi-agency audits through the representatives on the Quality of Practice Performance (QPP) Sub Group. To ensure that frontline staff who are involved in the case attend the audit.
2. The CSE risk assessment needs to be reworked to include wider issues of exploitation (such as criminal exploitation), and the risk/impact of on-line CSE on victims' emotional wellbeing.
3. Closer monitoring of staff changeovers of cases, aiming to reduce the turnover of the number of staff assigned/re-assigned to specific cases, and ensuring that staff are conducting appropriate handovers for vulnerable young people.
4. Training needs identified in relation to SEN/Additional needs children and the additional risks of sexual and/or criminal exploitation.

03 – Learning from Missing cases:

•Where there was evidence of criminal behaviour from the young people, some agencies, particularly the Police, focused on the young people as perpetrators seemingly ignoring the impact on them of being victims of neglect/abuse/criminal exploitation.

•Parents and frontline workers identified a lack in Police recording and response to frequent missing episodes.

•The placement of vulnerable young people was not suitable and in some cases led to involvement with criminal activity that had not been present prior to them becoming looked after.

•There was a very clear gender divide in response to missing children, when boys and young men were being reported missing, little effort was being made to locate them and establish their safety/return them home

•Appropriate case handovers between frontline workers needs to be carried out with vulnerable young people, many of whom had attachment issues.

06 – Recommendations for Frontline Practitioners:

1. Frontline practitioners to ensure that they attend the audit when invited.
2. Actively challenge parents/families who they suspect of disguised compliance by directly challenging the incidents where they believe families are avoiding/making excuses for meetings, visits, interventions.
3. Work with families and young people to increase attendance at multi-agency meetings, particularly with older children, so they are actively engaged in the process and desired outcomes.
4. All agencies to ensure that they attend multi-agency meetings and/or send reports, take ownership of their agencies actions from the meetings, and work collaboratively to move cases forward.
5. Adult services should be invited to and attend multi-agency meetings when they are involved with parents/carers of the child/young person.
6. To feel confident to challenge other agencies if they do not agree with their escalation/de-escalation of risk for specific cases. This should be done using the 'Managing Professional Disagreement' Policy, available on the SSCB Website.

05 – Evidence of Good Practice:

Q3 Academies demonstrated excellent work with the young person in one case. They showed a determination to support and engage with the young person in very difficult circumstances, particularly the pastoral care for the school. They managed to keep the young person in school and they gained some qualifications, the school remained consistent in their approach and frontline staff showed commitment and dedication to this young person that they had not experienced in other areas of their life. This had a big impact on this young person's prospects and demonstrated the importance on a stable educational setting for vulnerable young people.

In another case the CAMHS worker showed persistence and consistency with the young person that was slowly beginning to effect change in the young person's willingness to engage.

04 – Learning from all cases:

•In cases where the young person had some form of Special Education Need, this was a significant factor in their increased vulnerabilities. These needs were not being successfully managed by the agencies involved with the child and family.

•Lack of information sharing, particularly from the Police in relation to the missing children, which meant that not all concerns were known by all agencies, leading to different interpretations of risk.

•Agencies were only examining the presenting problem or looking at the child's behaviour, without looking at history to ensure that the right interventions were in place, and examining family history/dynamics and parents' behaviour.

•Sporadic and inconsistent multi-agency meetings, which led to drift and delay, and escalations in risk without any practical work being completed with families.

•Agencies were not always clear on thresholds for significant harm and/or multi-agency escalation policies if they wanted to challenge other agencies on their risk management/escalation/de-escalation of cases.

•Education was a concern with very sporadic engagement with education, where some schools were actively seeking to ensure the young person was attending and engaging, and other providers were not able to offer the level of support needed for the complexities of these cases.