BROMLEY SAFEGUARDING CHILDREN BOARD

MULTI AGENCY AUDIT 2017

CHILD SEXUAL EXPLOITATION (CSE)

AISLING CLARE

INDEX

1. Executive Summary

This audit revisited 18 CSE cases which were audited by the BSCB in 2015, and in addition audited 5 recent CSE cases (August 2016- January 2017).

The 2017 audit was undertaken prior to the formation of the Atlas Team whereby there have been significant improvements to the process and resourcing of CSE work within Bromley.

Key Findings

Identifying CSE

- There were missed opportunities around early intervention because of **failure across agencies to identify early warning signs of CSE**. CSC cases closed and re-opened in quick succession. Some chronologies were ineffective around early identification of CSE.

MAP and Strategy meetings

- Strategy meetings evidenced considerable **variation in multi-agency participation** and **some delays**.
- The **parallel processes** and functions of MAP and case working may have impacted on timeliness and momentum of the work.
- MAP meetings were **regularly the sole multi agency forum** - these professionals meetings did not include the full professional network who were working with the child and parent.
- The effectiveness and rigour of **MAP meetings varied** widely around partnership working, the quality of CSE work and planning.
- Some MAP meeting minutes were of an inadequate standard and or records were missing.
- **MAP Plans were not always outcome focused** and review of plans did not record the impact of completed tasks on the child/ parent.
- Partner agencies particularly **GP and schools were regularly lacking MAP information**.

Responding to CSE

- There was evidence of **committed and skilled work** across agencies including effective partnership working responding to identified CSE.
- There was an **absence of working in partnership with children and parents through timely multi agency meetings:** there were missed opportunities around maximising the impact of single agency work through multi agency meetings with children and parents participating directly in the work. On some cases no meetings had taken place within the 6 month timeframe (with the exception of CP cases).
- **Safety plans and Return Home Interviews had not been completed** or were completed after lengthy delays.

- **Failures in CSC processes in cross borough working** around Section 47 and instigating a Private Fostering assessment.
- The **voice of the child was variable** in key documents such as Safety Plans especially around their consent or disagreement to plans.
- **Aspects of diversity were identified** however their affect on the child needed more focus.
- A child who had **multiple additional needs in respect of diversity** was the recipient of **collective failures in processes**.
- **Specialist services around CSE were not available in a timely manner** particularly for young people experiencing high levels of CSE with additional vulnerabilities.
- There was **a range of skill levels evident in direct CSE work with young people** ranging from episodic and ineffective to skilled and thoughtful work. There was an example of **outstanding work from a school**.
- **Limited parenting work was evident around promoting parents' understanding of CSE and protective capacities towards their children**. The connections between parental neglect and or abuse with a young person's unmet emotional & psychological needs and their vulnerability to CSE needed to be more fully considered and planned around.

Management Oversight

- **Management oversight was variable** around ensuring that processes are instigated in a timely and proportionate manner towards identified outcomes to prevent drift and delay.
- Effective Reflective supervision was evident for some cases however **most cases did not have any reflective elements.**

Disruptions and prosecutions

- Police Intervention is demonstrating the **regular use of disruption tactics**.
- Overall there are a **low number of convictions** (3 CSE related convictions for the 2015 sample group and no convictions for the 2017 sample group).
- The lack of evidential basis necessary for criminal proceedings were linked to young people's fears around the repercussions of criminal investigations. This is an area which needs further focus especially around re-visiting closed cases to support children and young people in pursuing prosecutions.
- One case of high level CSE evidenced significant failures of processes and practice across agencies - the impact of collective failures is likely to be a contributory factor around a young person's ability to work with a criminal prosecution.

2. Introduction

Bromley Safeguarding Children Board (BSCB) undertakes a rolling programme of audits and this report provides an overview of the audit undertaken in March 2017 which focused on the effectiveness of multi agency service provision around Child Sexual Exploitation (CSE). This work was carried out by an external auditor on behalf of the Quality Assurance and Performance Monitoring (QAPM) sub–group of BSCB.

The audit reports on the journeys of children and young people experiencing CSE and multi agency service provision from 2014 until the current day. The report is divided into two parts : the first part focuses on 5 recent CSE cases (August 2016 – January 2017) providing an evidence-based assessment on the strengths and areas for development of the partnership working. The second part revisits the 18 cases analysed in the BSCB's 2015 multi agency audit '*CSE Audit: Bromley MASE referrals reviewed'*.

PART 1

3. Methodology of 2017 audit

The 2017 audit sample group were selected on the basis of: under 16 years of age; a significant level of CSE; open cases from August 2016 to January 2017. There was a selection of age, ethnicity and multi-agency involvement. Diversity around gender and disability were also part of the criteria however there were no young people identified who were male or had an identified disability. The 5 cases consisted of 1 Child Protection (CP)case, 1 Looked After Child, (LAC) 1 Private Fostering (PF) case and 2 Child In Need (CIN) cases.

Meetings were held with agency leads and auditors for Police, Health and Education to input into the design of the audit tool resulting in agency specific tools. This was in response to feedback from the BSCB 2017 Neglect Audit around the multi-agency audit tool being social work centric.

Partner agencies confirmed whether they had provided a service to the young people within the audit timeframe. No services were provided by : Bromley Youth Support Programme, Community Paediatric Team, Bromley Healthcare (BHC) Contraception and Reproductive Health (CRHS).

Records were reviewed taking into account the history of service provision. A structured questionnaire focused on five key areas of activity: Identification of CSE; Partnership Working; Voice of the Child; Intervention; Supervision and Management. Gradings were completed in line with OFSTED's current framework. Some audits were not graded when auditors felt that they were

unable to make a reasonable judgment because of limited service provision. There was also concern from some agencies around exposing difficulties and or deficits within their services. The overall gradings have not been externally moderated.

Contact was made with 4 of the young people to invite them to provide their feedback by meeting with the Auditor together with a QAPM Board member. This was unsuccessful as no responses were received.

A full quota of Bromley audits were received (Out Of Borough school and GP did not respond to audit requests). Many of the questionnaires were completed with a well evidenced context demonstrating rigour in their grading particularly evident in some agencies who had previously participated in the BSCB 2017 Neglect Audit. A smaller number were completed less thoroughly and some audits had a central focus on procedural compliance with less evidence around the quality and the impact of the work. CSC Social Worker's (SW) perspectives were invited through reflective feedback forms. Two completed forms were received (3 SW's were no longer in post).

Multi agency audit Submissions

CHILD A

Young person had previously been the subject of 2 referrals resulting in one short period of involvement related to domestic abuse. The first CSE referral for peer on peer CSE including social media occurred when the young person was aged 12 resulting in a brief period of CSC involvement. A re-referral around risks of CSE and emotional vulnerability was made from a Health agency however the case was not re-opened. The case re-opened 6 months later in relation to pregnancy and sexual relationships. In the audit period the case closed and re-opened within a week for a CSE peer incident in exchange for drugs involving social media. The risk moved from Level 1 to Level 2 CSE. An offending incident took place.

4 Child A - Children's Social Care

Effective multi agency perspectives were communicated and robust planning achieved in strategy discussions however there were some delays in them taking place. There was a 3 month delay in a Safety Plan being completed.

The assessment covered salient areas however analysis of the information was lacking around contrasting perspectives from family and professionals. There is an effective chronology.

A timely MAP meeting took place with detailed minutes around the context and contributing factors of CSE however the outcome and impact of multi agency work was not always clear.

There were deficits in partnership working with education and health in the context of peer relationships within school being pivotal and health issues being a factor.

The young person's voice emerges with a layered understanding of their views, including discussions of the Initial Child Protection Conference (ICPC) and Plan. CSE work is effective with the SW facilitating the young person discussing her experiences around CSE.

The CP plan is progressing the work in most areas. There was a lack of analysis, planning and intervention around parenting capacity and or family functioning (such as adolescents parenting classes /family therapy) on the basis of the parent minimising these issues.

Supervision was ineffective around the early identification of CSE where the case closed prematurely without plans around known vulnerabilities to CSE. Subsequently management oversight explicates the context of CSE in a manner which effectively assists the Assessed and Supported Year in Employment (ASYE) SW'S understanding of CSE.

Overall Grading - Requires Improvement: Ineffective response around early identification followed by a CP plan. Variable partnership working with deficits in inter- agency work with school and GP.

Child A - Practitioner Case Reflection

The challenges were the young person's denial and lack of understanding of CSE. Progress was made through the very good relationship the practitioner built with the young person: this enabled the young person to self-reflect on some issues which the practitioner felt was very positive.

5. Child A – Police

There were 7 contacts with the police prior to CSE being identified (MASH were notified on each occasion). A Police National Computer (PNC) marker for CSE was recorded within 2 weeks.

The young person was seen by the police on the day of CSE being identified and she was seen by the CSE team on the following day. The young person worked well with officers however she did not support further criminal investigation. A suspect received a Section 2 Abduction Notice.

Overall Grading: Requires Improvement. CSE indicators were not correctly identified on the previous occasions that the child had come to police notice.

6. Child A - School

Partnership work with CSC was variable whilst there was effective work with the police. School did not attend the Initial Child Protection Conference (ICPC) due to not being aware of the date. The first Core Group lacked effectiveness as Schools and CSC were the only attendees.

The young person was supported by staff and responded to strategies (achievement points).

Overall Grading – *not completed. Management and Supervision details were not provided.*

7. Child A – GP

Limited partnership working impacted on identification and intervention. There was a missed opportunity around exploring CSE associated with social media in relation to the parent relaying the young person would miss school and spend all day on an iPad (self harm, depression and poor school attendance were identified including associated triggers and strengths).

In the early stages CSC did not share the nature of the concern when requesting information from GP's nor did they provide an outcome to the information request. The GP information to CSC neglected to include all salient information (a CAMHS referral and poor school attendance). The GP was not invited to the MAP meeting nor received any information from the meeting.

There were deficits in the transfer of information within the health economy: there was no information detailing the CAMHS referral outcome.

Support was given to the GP trainee by her trainer.

Overall Grading: Requires Improvement

8. Child A - School Nurse Service

This young person was not seen directly within the timeframe**.** The ICPC was attended.

Overall Grading: Good. The School Nursing Service are severely restricted around capacity and are unable to make regular assessments or attend Review Child Protection Conferences unless health needs are identified. There is currently a minimal service with no option of an enhanced service.

CHILD B

There were 2 referrals to another Local Authority (LA) in relation to poverty and Private Fostering (PF). Aged 10 there was a police missing report. Aged 14 the young person had been gang raped by 3-4 males on 4 occasions and by 1 male on one occasion. The crimes had taken place in another LA so MASH referred the CSE to this LA and the case was not opened (despite information around the Private Fostering arrangement). In the audit period the case opened due to a further referral from a Health agency. Level 2 CSE was identified. No audit returns were received from (Out of Borough) School and (Out of Borough)GP.

9. Child B - Children's Social Care

There were major failures in process by Bromley resulting in no CSC services in place for 3 months. The referral to another LA had was not followed up by Bromley to ensure that it was received and actioned. A PF assessment was not initiated despite police information of a PF arrangement. 'Triple Lock' review identified the failures and instigated remedial action.

A skilled social work assessment and chronology captured the complex history and dynamics with awareness of both systemic vulnerabilities (PF, temporary housing and poverty) together with household dynamics - a family culture of secrets. There were acute observational details (anomalies in contrasting reactions to a burn mark by the young person and parent). The significance of factors around the context of CSE needed further focus despite no current presenting issues (eg neglectful parenting, substance misuse, financial rewards).

Management oversight steered the assessment. Reflective discussion responded to the SW's concerns. There was evidence of internal escalation around delays in providing a Barnados service.

The initial MAP meeting minutes lacked analysis or hypothesis around the uncommon CSE pattern. There are no MAP minutes for the final (second) MAP meeting. There is no multi agency plan.

Good communication between the SW and GP, school and parents around the young person's emerging health issues with detailed information on diagnosis and medication.

Skilful direct work through regular home visits has facilitated the child's voice emerging whilst the lengthy delay around services may have compounded a sense of her voice not being wanted.

There was no Safety Plan - it was unclear whether the young person agreed or dissented to monitoring measures. The case narrative relays this young person's discontent at severe restrictions:

there was a lack of detail around the nature of the restrictions together with professional judgement as to whether they promoted independence, social and emotional needs balanced with safety. There was attention to and discussion of cultural differences. Balance was achieved between sensitivity whilst not obscuring the role of the adults in the family functioning related to a young person's vulnerability around high levels of CSE.

Overall: Requires Improvement. Wide variations in case working from major failure in processes, deficits in multi agency planning contrasting with high quality SW assessment and direct work.

10. Child B – Police

There was 1 prior contact where CSC were notified. The PNC marker was completed within 24 hours. The young person was seen by the CSE officer and the Sexual Offences Investigatory Trained (SOIT) officer on the same day of the CSE being reported. No suspects were identified due to the young person not wishing to engage with any police officers.

Further efforts to engage the parent(s) may have had a better result.

Some supervision was not conducted in line with policy.

Overall; Good. CSE identified at an early stage

11. Child B - Barnardos

High quality information was provided from the CSC referral and Information was augmented at a referral meeting evidenced in detailed minutes.

A Barnardos' risk assessment had not been completed and supervision had been recorded on the worker's personal file contravening policy. Immediate action took place to rectify this.

The MAP meeting was attended however there are no MAP plans or other CSC plans.

The Project worker found a suitable venue for direct work taking into account the sensibility of the YP however expediting this at an early stage would have resulted in earlier intervention.

Overall: Not graded due to the limited intervention.

CHILD C

No previous referrals. **3 missing episodes,** ***associated with mental illness 2 of which involved inappropriate relationships and a third incident where the young person was raped by 4 men. Level 2 CSE was identified.***

12. Child C - Children's Social Care

Clear actions, timescales & outcomes recorded in a Strategy discussion however some delay around this taking place. There was also a significant time lapse in Return Home Interviews (RHI) being undertaken (2 RHI's each with 2 week delays). There was no Safety Plan.

The assessment lacks focus on parental capacities and history with limited multi agency input (CAMHS views were not included). Socio-economic factors around class may have contributed to the young person's mental health being viewed in isolation to the family functioning. There was drift and delay around accomplishing parenting work.

There is a lack of management continuity and grip around differences of opinion around the case direction. Supervision actions are not reviewed with repeated directions not being actioned. 'Triple Lock' Review provided effective oversight around remedying the case direction and planning.

Timely, effective MAP meetings included representation from school. There was an absence of recorded CHIN meetings or network meetings until 7 months into case working.

Limited social work visits were evident: Further focus was needed around gender and culture which underpinned the young person's extreme views around endorsing sexual violence to women.

Overall grading: Requires Improvement. A lack of management continuity contributes to drift and delay and deficits in co-ordinated outcome focused planning.

Child C - Practitioner Case Reflection

The SW' reflection included transferring the case under a Child in Need Plan to prevent drift.
The challenges were differences of opinions within the network around reaching the threshold for a Child Protection Plan contrasting with the social worker's view.

13. Child C – Police

The Young person was seen by the SOIT/CSE officer on the same day of 2 incidences of CSE. A PNC marker was completed within 24 hours. The young person engaged well with the Intervention Officer however she did not support a prosecution for rape when suspects were arrested.

The 'Prevent' Police Officer advised the young person and family on radicalisation. The family reported that they received outstanding police response/support**.**

Overall: Good. Safeguarding measures and interagency work were of a good standard.

14. Child C - School

CSE concerns were not shared by CSC in a timely manner which prevented the school having an informed approach. Repercussions included the school's actions being criticised within the professional network when the school had had no knowledge of crucial information.

The 2 MAP meetings achieved greater clarity about events which parents were reluctant to share together with understanding the perspective of other agencies around the complex case issues.

There was discussion of plans in relation to missing episodes with the family. There was also discussion with the young person around wearing a headscarf as she was interested in the Muslim faith.

Overall – Good.

15. Child C – GP

The signs of potential CSE were not identified whereby there were delays around making a referral to CAMHS (vulnerabilities around missing episodes and strengths had been identified as the young person had discussed her concerns whilst being seen alone by the GP.

There was limited communication with partner agencies. A report was provided for MAP however no information was subsequently received from MAP or case updates from CSC. The GP had not been invited to participate in Strategy meetings or network meetings so plans were unknown.

Good medical care was achieved with the network of health services.

The GP sought advice from the surgery Clinical Safeguarding Lead and subsequently decided not to refer to MASH against advice from the Lead on the basis that there was effective support.

Overall Grading: Requires Improvement

16. Child C - CAMHS

Communication with CSC was difficult at times. CSC had planned to close the case prematurely however they took heed of CAMHS' concerns around ongoing CSE.

CAMHS were not invited to the MAP and are unaware of plans. CAMHS contributed indirectly to a Strategy discussion via A and E staff.

Linked up care from private and public health providers was a challenge. A change of clinician occurred due to sickness which impeded the CAMHS intervention. A referral had been made for Tier 4 Dialectical behaviour therapy (DBT).

This case was discussed in Multi Disciplinary Team meetings. The learning from this case was around convening an early professionals meeting to achieve clarity and consensus around what elements of the case were mental health issues as distinct from safeguarding issues.

Overall: Good

CHILD D

Aged 13 there was an overnight missing episode resulting in a short period of CSC assessment. There was a referral for lack of parental supervision and exposure to substance misuse. In the audit timeframe the case closed and re-opened the following month with a CSE referral (inappropriate relationship with a man). Level 1 CSE was identified.

17. Child D - Children's Social Care

Case closure occurred without identifying the warning signs of CSE - there was a lack of analysis around the family's rebuttal of concerns. The chronology was ineffective at identifying CSE (eg a missing episode failed to include the context of missing overnight). There was no Safety Plan.

There was a delayed, ineffective response to identified CSE both in the setting of management directions and direct contact with the young person (CSE was explored in a telephone conversation–a SW visit took place at school 3 weeks later). SW visits were infrequent and there was a lack skilled support to the young person around exploring sensitive areas of her experiences.

The MAP minutes are brief and ineffective with limited planning. A CHIN plan lacks focus around the outcomes sought for each goal.

Professional curiosity and critical analysis were lacking around the ambivalent, mixed responses from family members and little work was accomplished with the parent. Sexual health was absent as a focus of the work until the young person became pregnant aged 14 (despite rumours around a pregnancy in the previous year).

Supervision records have insufficient content and no reflective supervision. Management actions miss key areas around relationships and sexual health and do not address deficits in the assessment.

Overall Grading: Inadequate. Ineffective assessment and planning are not addressed by effective management oversight. sexual health and relationships are absent until pregnancy occurs.

18. Child D -Police

Police had 3 episodes of prior contact with the young person where MASH had been notified. A PNC marker was recorded within 3 weeks. The young person who was seen by the CSE officer within a week. There was a delay in serving a Child Abduction Warning Notice due to identifying the young people of concern: (A large group of young people had been associating around a CSE hot spot).

Good interagency working however further work was needed around the parents/carer.

Overall Grading: Requires Improvement. The timeliness could have been better from police.

19. Child D - School

School had been pro active in early intervention with the young person and her parents in response to rumours around risky behaviours in the previous school year.

There was a lack of information sharing which impeded the identification of CSE. School were unaware of the MAP meeting (whilst attending every meeting they have known about).: the parents were not fully aware (or wanted to be) of the risks and were ambivalent about safeguarding services.

A complex strategy meeting where young people at risk of CSE were discussed from schools around the area was very useful and the School police liaison officers were particularly helpful.

A good working relationship between the young person, the parents and school supported the young person who maintained her good attendance. The Voice of the Child was a particular strength as the young person and the Designated Safeguarding Lead (DSL) had a strong relationship. The DSL provided consistency and effective monitoring. The young person shared her pregnancy and sought support when difficulties arose with other students. It appeared that the young person felt listened to and understood that School viewed her individuality as important.

The young person experienced the trauma of pregnancy at a young age which may have been averted by accessible sexual health services however the parents may not have been open to this.

'I feel that the jury is still out on how effective we all have been in promoting change for this young person'.

Overall Grading – Good.

20. Child D – GP

Excellent records detail enquiries about sexual partner(s), recording that the relationship was fully consensual. Appropriate medical referrals were made reducing physical risks.

CSC requested information without sharing the nature of concern or providing any feedback after the report was sent. The GP was not invited to the MAP meetings and have not received any information from it.

Overall Grading: Requires Improvement.

21. Child D – Princess Royal University Hospital (PRUH)

The clinician spoke to the young person alone in a sensitive manner. A ' Keep Your-Self Safe' KYSS form (Kings sexual health safeguarding proforma for under 18 year olds) was not completed. The documentation did not include whether a referral was made to CSC.

Overall Grading: No grading determined

Child E

Aged 9 there was a sexual assault by her sister's boyfriend. Family dysfunction and violence related to missing episodes beginning aged 13 lasting up to a week at time. Aged 13 being groomed online and sending inappropriate messages and pictures. Aged 14 the young person alleged sexual assault and being held against her will. Aged 15 CSE videos circulating. Case closure took place due to yp re-locating abroad. During the audit period Level 2 CSE identified involving gang affiliations and offending. The Young person became Looked After.

22. Child E- Children's Social Care

Effective response and timely multi agency strategy discussion with consideration of history and good chronology. No Safety Plan was completed

MAP minutes contained only basic information. The lack of record keeping detracted from the effectiveness of multi agency work contrasting with the case narrative evidencing proactive work.

The young person's voice is heard around her complicated experiences of CSE and abusive family experience - she retracted allegations of sexual abuse/ CSE on 2 occasions. The young person's wishes around ethnicity & religion informed matching around foster carers.

Managerial oversight steers the case from a number of layers, first line manager, Group Manager , Head of Service, 'Triple Lock' review. Police concerns around the location of placement associated with high absconding risk are responded to in an effective manner by identifying an alternative placement.

Overall Grading: Requires Improvement: Proactive response to missing episodes and rigour around reducing risk. Recording did not capture all the work taking place around complex risks.

23. Child E - Police

There were 3 prior contacts which were notified to MASH. A PNC marker was recorded within 24 hours. The young person was seen by police within a week of concerns being identified and she was subsequently placed in Police Protection. A Section 2 Abduction Notice was served however the young person did not support a prosecution. Extensive missing episodes impeded planning to reduce risk factors in the formulation of a Safety Plan.

There was a good working relationship between Missing Person unit, CSE officer and CSC.

Communication with the family was an issue raised by the family in relation to some officers whilst the family spoke highly of certain officers/departments.

Overall Grading : Requires Improvement: Risk management was lacking in effectiveness due to the difficulties engaging with the young person.

24. Child E – School

Effective partnership work between School, CSC, the police and the Missing Person Unit with daily inter agency communication immediately following the triggering incident.

There was a lack of timely information sharing between Bromley schools (previous and current) whereby there was a 3 month delay in receiving the student's file from her previous school detailing safeguarding issues(A recent school transfer has taken place because of bullying).

A MAP meeting was effective at discussing the complex issues. School has attended all meetings.

Overall Grading: No grading determined.

25. Child E – LAC Nursing Team- Bromley Healthcare

The young person's voice informed the Initial Health Assessment (IHA) which was completed in a timely manner. Adverse childhood experiences were discussed. A referral to CAMHS was made.

Overall Grading: Good: Timely interagency working incorporating the voice of the child.

PART 2

26. 2015 '*CSE Audit: Bromley MASE referrals reviewed'*

QAPM originally requested a review of the 2015 audit to provide a longer term analysis of multi-agency service impact on children's outcomes. The conclusion of the 2015 report had indicated positive impact: '***Following referral into the Multi Agency Sexual Exploitation (MASE) Panel significant positive changes have been seen in all the cases audited. This offers us very credible evidence that the tackling Child Sex Exploitation procedure developed by Bromley Safeguarding Children's Board is working well when risk cases, even at a low level, are identified and referred.'***

The 2015 audit reviewed the effectiveness of processes to refer, support and plan around the risk of CSE. 18 children and young people were selected who were referred to the MASE panel. The sample was randomised but differentiated to include different ethnicities, genders, children who were looked after and those who were not. The agencies involved were CSC, Police, CAMHS and Princess Royal University Hospital (PRUH). Lead auditors rated domain headings (*no risk identified/low risk/ medium risk/high risk*) together with a summary evaluation of cases. Each finding was rated at the time of the referral to the MASE panel and then rated again during the audit period or at case closure.

The challenges around reviewing the sample group were that many are now in the 18 plus age group and would have had no further service input. This limited the purposefulness of a comprehensive audit: for these reasons a review of cases is provided from CSC records augmenting the 2015 synopsis with the context of CSE together with what is known about the young person's most recent outcomes. Police information has also been provided. The original 2015 Audit risk assessment ratings have been tabulated followed by 2017 updates.

27. 2017 Case updates of 2015 *CSE Audit*

CASE 1 - ***A female aged 19 at the time of the 2015 Audit (She was aged 16 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Going missing	**High**	**No risk**
Sexualised risk taking	**Medium**	**Low risk**
Contact with abusive adults	**High**	**No risk**
Substance misuse	**High**	**No risk**
Family relationship	**High**	**No risk**

This service user experienced a high level of organised sexual exploitation from numerous perpetrators over a period of 4 years beginning aged 13 in the context of family conflict. An inappropriate relationship gradually progressed (including online exploitation) whereby she was controlled by a number of men through violence. She had very significant substance misuse problems using Ketamine, Methanol and alcohol for physical relief of pain after the sexual assaults.

This young woman made repeated attempts to exit sexual exploitation. No suspects were identified by the police.

2017 UPDATE: Now 21 years old and receiving a service from the Leaving Care Team (LCT). This service user has some mental health issues which are impacting on her being able to work or attend college. Family relationships are difficult. This young woman struggles to accept support within her professional network. There are current concerns about sex work.

CASE 2 ***- A female aged 18 at the time of the 2015 audit (She was aged 15 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Engagement with Services	**High**	**No risk**
Emotional Health	**High**	**No risk**
Other Factors	**Low – Medium**	**No risk**

This young woman was the victim of Intra-Familial Sexual Abuse at aged 5 years. Aged 15 an attempted rape took place by 3 boys at school on 2 occasions and multiple suicide attempts were made during this period. The police did not identify any suspects as the young person did not support the investigation.

2017 UPDATE: No further contact. On case closure this young woman was achieving in her education. Sexual health work had been attempted. Substance misuse was not an issue.

CASE 3 - ***A female aged 18 at the time of the 2015 Audit (She was aged 15 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Going missing	**High**	**Low risk**
Sexualised risk taking	**High**	**Low risk**
Contact with abusive adults	**High**	**Low risk**

There were no further episodes of CSE following a period characterised by family rejection, mental health crisis, involvement with gangs, drugs, offending as well as CSE. The adults who had been harbouring her in a brothel were charged in 2013, The young person supported their prosecution.

2017 UPDATE: This 20 year old young woman lives independently and is the mother of a baby. The baby's father has served a recent prison sentence for drugs and violence –both are co-parenting their child whilst being separated. This young woman has a supportive family network. This young woman has good physical health. She has achieved in her education.

CASE 4 - ***A female aged 18 at the time of the 2015 Audit (She was aged 16 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Education	**Medium**	**High risk**
Family Relationships	**Medium**	**High risk**
Engagement with services	**Low**	**Medium**
Risk of CSE	***Not specified***	**Reduced risk**

The case closed as there was no evidence of CSE (whilst there was some uncertainty). Police did not identify a suspect as the young person was fearful around identifying perpetrators.

2017 UPDATE: A re –referral took place shortly after case closure due to pregnancy. A Pre-Birth assessment was initiated however the young person disclosed that she had a miscarriage caused by the emotional trauma of her relationship breakdown involving domestic abuse.

CASE 5 - ***Female aged 14 at the time of the 2015 Audit (She was aged 13 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Running Away	**High**	**No risk**
Education	**High**	**No risk**
Risk of violence	**High**	**No risk**
Emotional Health	**Medium**	**Low risk**

2017 UPDATE: This 17 year old has been in a stable placement for 3 years where she has positive relationships and is coping with social/ emotional issues. No self-harming has occurred in the past year. The young person is generally in good health. The young person is achieving in her education.

There are no concerns around CSE (she was originally assessed as vulnerable to CSE due to a serious sexual assault and missing episodes). The police served a Section 2 notice on the perpetrator.

CASE 6 - ***female aged 15 at the time of the 2015 Audit (She was aged 14 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Running Away	**High**	**No risk**
Education risk	**High**	**No risk**
Risk to others	**High**	**No risk**

The young person was accommodated because of an inappropriate relationship and missing episodes. The police served a Section 2 Abduction Notice. The family history Includes: neglect, parental substance misuse, parental mental health (multiple suicide attempts) and violence.

2017 UPDATE: 17 year old's case was closed on placement with a family member. The young person was achieving in her education. The young person was in good health. No concerns had surfaced around missing, CSE or offending.

CASE 7 - ***Male aged 14 at the time of the 2015 Audit (He was aged 12 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Sexualised risk taking	**Low risk**	**No Risk**

There were grooming concerns whereby the young person had sent sexualised pictures online. No perpetrator was identified as the young person was unwilling to participate with the police.

2017 No further contact.

CASE 8 - ***Male aged 15 at the time of the 2015 Audit (He was aged 14 on referral to MASE)***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Engagement with Services	**Medium**	**Medium**
Sexualised risk taking	**Medium**	**Medium**
Contact with abusive adults	**Low**	**No risk**

This young person was meeting older males who had groomed him online. Police identified a perpetrator and this person was charged and convicted of sexual activity with a child.

2017 UPDATE: No further contact. Family moved out of Bromley during 2014 service intervention.

CASE 9 - ***Female aged 17 at the time of the 2015 Audit (She was aged 15 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Engagement with Services	High	High
Education	High	High
Going missing	High	High
Risks of rewards	High	High
Substance Misuse	High	High
Emotional Health	High	High
Family Relationships	High	High
Risks to Others	High	Medium
Accommodation	High	Low risk
Experience of violence	High	No risk
Coercion	High	No risk
Sexual Health	High	No risk

This young person was raped at the age of 12 and had regular missing episodes due to extreme family conflict and emotional abuse. Aged 14 there were concerns around grooming from older men who would supply her with drugs and alcohol. A criminal conviction was made for giving a controlled substance to a minor.

2017 UPDATE: No further contact following the young person becoming homeless aged 16 and a placement in supported housing.

Case 10 - ***A female aged 15 at the time of the 2015 Audit (She was aged 14 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Engagement with Services	High	No Risk
Sexualised Risk taking	High	No Risk
Emotional Health	Medium	Low

This young person suffered online exploitation by a much older man. A complex construction of multiple personas manipulated and controlled her into providing sexual images. The perpetrator was convicted of grooming and possessing indecent images. The young person's self-harming pre-dated the CSE but escalated during this period.

2017 UPDATE: No further contact

CASE 11 - ***Female aged 14 at the time of the 2015 Audit (She was aged 13 on referral to MASE)***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Family Relationship	High	No Risk
Sexualised Risk taking	Medium	No Risk
Going Missing	Medium	No Risk
Education	Medium	No Risk
Accommodation	Medium	No Risk
Experience of violence	Medium	No Risk
Going Missing	Medium	No Risk

The young person had had a number of episodes of Local Authority care for being beyond parental control with a family background of physical abuse. Prolific missing episodes began at aged 12 and intermittent concerns around sexual exploitation at aged 13. No suspects were identified.

2017 UPDATE: This 16 year old is receiving a service from the Leaving Care Team. She has achieved in her education. The young person has good physical health. There are vulnerabilities to CSE and missing episodes. There is a highly conflictual family relationship.

CASE 12 - ***Female aged 16 at the time of the 2015 Audit (She was aged 15 on referral to MASE.***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Sexualised Health	High	No Risk
Running away	Medium	Low Risk
Family Relationships	Medium	No Risk
Risk to others	Medium	No Risk
Substance misuse	Medium	No Risk
Experience of violence	Medium	No Risk
Emotional health	Low	Low Risk

Coercion	**Low**	**Low Risk**
Contact with abusive others	**Low**	**Low Risk**
Accommodation	**Low**	**No Risk**
Sexual exploitation	**Low**	**No Risk**

This young person experienced a chaotic childhood characterised by chronic neglect including parental mental illness, serious domestic abuse, substance misuse and anti-social behaviour. Aged 2 she was sexually abused by a family friend. Self-harming dated to when she was 11 years old. Poor school attendance developed into prolific episodes of missing both in her family placement and subsequent Local Authority placements. This young person had multiple pregnancies.

The young person would not engage with police so no suspects were arrested.

2017 UPDATE:18 year old is the mother of a baby who is subject to a Care Order.

CASE 13 - ***Female aged 17 at the time of the 2015 Audit (She was aged 17 on referral to MASE)***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Family Relationship	**High**	**High Risk**
Emotional health	**High**	**Low Risk**
Going missing	**Medium**	**Medium Risk**
Experience of violence	**Medium**	**Medium Risk**
Coercion	**Medium**	**Medium Risk**
Contact with abusive others	**Medium**	**Medium Risk**
Sexualised risk taking	**Medium**	**Medium Risk**
Risk to others	**Medium**	**Medium Risk**

CSE was in relation to a long standing inappropriate relationship within the extended family. Honour Violence prevented the young person from ending the relationship together with her concerns around her perpetrator/ boyfriend's mental illness. The young person had multiple episodes of serious suicide attempts and hospital stays under sections. Homelessness and offending were contextual issues. No suspects were identified by the police as the relationship was international.

2017 UPDATE: Case closed due to poor engagement of the family who reported the young woman had left the UK.

CASE 14 - ***Male aged 15 at the time of the 2015 Audit (He was aged 15 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Family Relationships	High	Medium Risk
Conflict with Others	High	No risks
Experience of violence	High	No risks
Education	Medium	Medium Risk
Risk to others	Medium	Low Risk
Accommodation	Medium	No risks
Sexualised exploitation	Low	Medium Risk
Coercion	Low	Low Risk
Rewards	Low	No risks
Contact with abusive others	Low	No risks

The young person's family background was of intergenerational sexual abuse and incestuous relationships over 3 generations together with high level neglect and parental substance misuse. Aged 11 the young person alleged sexual abuse by an extended family member. Aged 12 was the first incident of perpetrating rape on another child and concerns around pornography. There were numerous concerns at school around Sexually Harmful Behaviour. Aged 13 the siblings of the young person alleged sexual abuse. The siblings were removed by court order a year later.

2017 UPDATE: Case closed with the transferral to another LA of a Care Plan to address Sexually Harmful Behaviours - the young person was assessed as a moderate risk of sexual harm to children. A referral was received a year ago for the young person's driving offences.

CASE 15- ***Female aged 15 at the time of the 2015 Audit (She was aged 11 on referral to MASE).***

No risk levels were provided in the 2015 report '***This case remained open to MASE at the time of the audit and concerns that had been missed when the young person was originally referred were now more clearly apparent. This meant that the audit had scored no risk at referral and up to medium risk at the time of the audit, which on face value is misleading.'***

The young person had a learning disability and concerns around inappropriate relationships began aged 13. A suspect was identified by the police however the young person retracted her statement. CSE work was of limited success due to her cognition and participation. School attendance and peer relationships remained an issue on case closure. Missing episodes from home and school had improved due to parenting work with her carer.

2017 UPDATE: No Further contact.

CASE 16 - ***Male aged 13 at the time of the 2015 Audit (He was aged 12 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Family Relationships	High	Low risk
Emotional health	High	Low risk
Education	High	Low risk
Contact with abusive others	High	No risks
Risk to others	Medium	Low risk
Experience of violence	Medium	Low risk
Engagement with services	medium	No risk
Rewards	Low	No risks
Sexualised risk taking	Low	No risk

The young person accessed Internet pornography and shared inappropriate photographs of himself to another young person online complicated by his neurodevelopmental factors. The parent wanted their child to be accommodated because of his sexualised behaviour. No suspects were identified.

2017 UPDATE: This 15 year old has been re-referred in the last year for a missing episode resulting in a Return Home Interview. The young person reported that family tensions led to his missing episode. The family were supportive and no welfare issues were identified.

CASE 17 - ***Female aged 16 at the time of the 2015 Audit (She was aged 12 on referral to MASE***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Accommodation	High	Low risk
Coercion or control	Medium	Low risk
Substance misuse	Medium	Low risk
Other measures	Medium - Low	No Risk

This young person became accommodated as she was beyond parental control with prolific episodes of missing before and after entering Local Authority care together with concerns around self harm, suicide ideation, substance misuse and offending. Aged 11 organised exploitation took place in a brothel associated with Albanian gangs. Lack of evidence prevented prosecution.

2017 UPDATE: 18 year old is now a parent living independently with her partner and baby. This is an enduring relationship with some incidences of domestic abuse.

The young person is in good health – substance misuse is not current. The young person has variable relationships with extended family and intermittent contact with support networks.

CASE 18 - ***Female aged 16 at the time of the 2015 Audit (She was aged 16 on referral to MASE).***

2015 AUDIT RISK FACTORS	REFERRAL TO MASE RISK ASSESSMENT	RISK ASSESSMENT AT CASE CLOSURE/ TIME OF 2015 AUDIT
Engagement with Services	**High**	**Medium**
Emotional health	**High**	**Low**
Substance Misuse	**High**	**No risk**
Sexual Health	**High**	**No risk**
Rewards	**High**	**No risk**
Running away	**High**	**No risk**
Sexualised risk taking	**High**	**No risk**
Accommodation	**Low**	**No risk**

The young person was exposed to parental domestic abuse and substance misuse throughout childhood. Aged 16 the young person was the victim of multiple gang rapes on at least 3 occasions. Lack of evidence prevented prosecution whilst suspects were identified.

CIN work described achieving progress around substance misuse; attaining and achieving within education together with parental work around family functioning.

2017 UPDATE: There were multiple referrals immediately following case closure prior to the young person's 18th birthday around missing; family breakdown; gang associations and substance misuse.

28. Service User Feedback from '2015 *CSE Audit: Bromley MASE referrals reviewed'*

Contact was made with the majority of the 2015 sample group to provide feedback on their experiences of multi agency services. (Service users were not contacted for feedback where their current address was unknown, they lived out of borough or had a very brief period of contact with CSC). This was unsuccessful – one service user agreed to meet however subsequently cancelled:

> ***"I'm very sorry to cancel on such short notice however Upon reflection i had such a negative experience with the care system, with the police and other organisations that I do not wish to dredge up the past by discussing it as I have made improvements in trying to move past these blatant misuses of power.***

29. Conclusion

Part 1 of this audit explored the service provision for young people experiencing a significant level of CSE (Level 2 was identified for 4 out of 5 cases). The audit evidences some good pockets of skilled practice and service provision across agencies however overall there are wide variations in the quality of services and consistency and rigour around process. Children and parents are working with agencies without participating directly in a a co-ordinated multi agency approach : strengthening capacity around protectiveness and resilience is impeded by the lack of joined up work.

Part 2 of this audit tracks information on the children and young people who were subject to the 2015 audit. There were generally optimistic views across agencies around evaluations of service provision. Some children do evidence positive outcomes which indicates effective work however on a number of cases the negative trajectories were a striking contrast to the evaluations of successful interventions and diminished risks. The lack of impact of services on these children is greatly concerning together with the particularly sobering feedback from the service user.

The 2017 audit focused on the experiences of under 16's however the 2015 re-audit evidences the challenges around CSE service provision for the 16- 18 age group leading to the 18 plus Care Leavers who are vulnerable around sex working.

The CSE cases sampled evidenced a prominent CSE theme in Bromley around peer on peer CSE usually including social media (3 out of 5 cases). There were particular challenges in working with this type of CSE for all parties, young person, family members and professionals in terms of insight and understanding. There are additional challenges around providing a skilled response around working with Sexually Harmful Behaviour of the perpetrators.

This audit report closes with an acknowledgement of significant changes in the external and internal operating context of CSE strategy during the timeframe of this audit. The national context includes a revised definition of CSE by the DFE – this does not include peer on peer CSE, however as this is a very significant aspect of the profile of CSE within Bromley it will continue to be a central focus of Bromley's local strategy. Bromley has also set up a specialist team, the Atlas Team, which is led by a CSE Co-ordinator. Improved responses to CSE include Bromley-wide CSE procedures and Return Home Interviews recently being undertaken by the Atlas team. Further changes to embed good across agencies are also underway.

30. Recommendations

1. Safety Plans to be promoted and implemented as per procedures, to include child's consent or disagreement to the Plan

2. Management actions to ensure CHIN / professional meetings are convened in a timely, regular manner as per Bromley procedures.

3. MAP to ensure their processes are correctly followed around partnership attendance at meetings and information sharing of meetings.

4. Case files to record when minutes are sent out and which agencies minutes are distributed to.

5. BSCB to commission multi agency training with a central focus on peer on peer CSE in response to the Bromley profile of CSE.

6. Escalation policy to be implemented by multi agency network in the event of ineffective plans and or information sharing to protect children from CSE

7. Service user involvement strategies to be developed to assist and support children and young people in giving their views on services.

8. Ensure our prevention and early intervention work is effective, particularly with local Secondary Schools & Academies to ensure young people at risk are promptly referred into MASH.

9. Return Home Interviews to be conducted within 72 hours in order to be effective.

31. Glossary

BSCB - Bromley Safeguarding Children Board

CAMHS- Child and Adolescent Mental Health Services

CHIN -Child in Need

CP- Child Protection

CSC- Children's Social Care

DSL -Designated Safeguarding Lead

EIFS- Early Intervention and Family Support

ICS - Integrated Children's System

ICPC – Initial Child Protection Conference

IHA- Initial Health Assessment

LAC- Looked After Child

MASH – Multi Agency Support Hub

PF – Private Fostering

QAPM – Quality Assurance and Performance Monitoring Sub Group (of the BSCB)

R & A- Referral & Assessment Service

RHI- Return Home Interviews

SOIT -Sexual Offences Investigatory Trained Officer

SW – Social Worker

TAC- Team Around the Child

YOS- Youth Offending Service