



**Serious Case Review Overview Report**

**In respect of:**

**Child S**

**Produced by Professor Pat Cantrill**

**April 2011**

<b>CONTENTS</b>	<b>Page</b>
<b>SECTION ONE – INTRODUCTION AND BACKGROUND</b>	<b>4</b>
1.1 Reason for conducting the review	4
1.2 Scope and process	5
1.3 Subjects	5
1.4 Time period	6
1.5 Terms of reference	7
1.6 Process	7
1.7 Membership of Serious Case Review Panel	9
1.8 Involvement of the family	11
1.9 Family Genogram	12
1.10 Summary of the case	12
1.11 Data about Child S and Infant A	12
1.12 Family Composition and background	14
 <b>SECTION TWO – THE CONTEXT OF SERVICE INVOLVEMENT</b>	 <b>18</b>
2.1 Setting the context	18
2.2 Rotherham	18
2.3 The Safeguarding system	19
2.4 Rotherham Children and Young People’s Plan	21
2.5 The Performance of Rotherham Childrens Trust	23
2.6 Performance Management	26
2.7 Rotherham Children and Young People Governance Structures	29
2.8 Workforce Planning	30
2.9 NHS Organisational Changes	32
2.10 Sexual exploitation and grooming	34
2.11 Conclusion Section 2	39
 <b>SECTION THREE – ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS</b>	 <b>41</b>
3.1 RMBC Childrens Social Care Services and Youth Offending service	41
3.2 RMBC Education Services	58
3.3 Youth and Targeted Services	73
3.4 NHS Rotherham -General practice	84
3.5 The Rotherham NHS Foundation Trust	91
3.6 NHS Rotherham Community Health Services	101
– School Nursing Service	101
– Learning Disability Services	104
– Community Paediatric Services	107
– Community Dental Services	107
– Health Visiting Services	107
3.7 Overall Analysis of Health Services	110
3.8 South Yorkshire Police	113
3.9 Conclusion Section 3	120

**SECTION FOUR– LEARNING LESSONS, IMPROVING SERVICES** **121**

4.1	A Child’s Journey	121
4.2	Lessons to be Learned	123
4.3	Terms of Reference	129
4.4	Overall Conclusions	140

**SECTION FIVE – RECOMMENDATIONS** **141**

Appendix One	Glossary	147
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Appendix Two (separate document)  
Chronology of Significant events and agency involvement Sept 2008 to Oct 2110

## SECTION ONE – Introduction and Background

### 1.0 Introduction.

This Serious Case Review looks at the circumstances surrounding the sudden unexpected death of a young woman Child S in Rotherham. On [REDACTED] as a result of a search by South Yorkshire Police, Child S's body was recovered from the canal. She had sustained multiple stab wounds. Child S was seventeen, was a single parent and had a four month old child, Infant A. Child S had been known to a number of agencies over a lengthy period. As a result of the incident, the Rotherham LSCB Serious Case Review Panel met to discuss the case and it was decided that a Serious Case Review would be recommended.

The Serious Case Review Panel was informed that following her death, charges of murder have been brought against two men aged 21 years and 17 years. The trial of the individuals arrested for the murder of Child S is due to take place later this year.

### 1.1 Reasons for Conducting the Review

Chapter 8 Regulation 5 of 'Working Together to Safeguard Children' 2010<sup>1</sup> requires that a Local Safeguarding Children Board considers undertaking a Serious Case Review in cases of serious sexual abuse and in cases where it is believed there has been serious impairment to the health and development of a child. The circumstances surrounding the death of Child S were considered consistent with these criteria and a Serious Case Review was commissioned.

The purpose of a Serious Case Review is to establish what happened, whether information was fully shared by the professionals involved and that procedures were appropriately followed, so that any deficiencies in services can be identified and lessons learned to minimise the risk for another child. This should also reassure the public and prevent the need or demand for further external inquiries.

The guiding principles which underpin a Serious Case Review are:

**Urgency** – agencies should take immediate action and follow this through as quickly as possible

**Impartiality** – those conducting the review should not have been directly involved with the child or the family

**Thoroughness** – all important factors should be considered

**Openness** – there should be no suspicion of concealment

**Confidentiality** – due regard should be paid to the balance of individual rights and the public interest

**Co-operation** – the agreed LSCB procedure and statutory guidance contained within 'Working Together to Safeguard Children' 2010 should be followed

**Resolution** – action should be taken to implement any recommendations that arise.

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<sup>1</sup> Working together to safeguard children a guide to interagency working to safeguard and promote the welfare of children DCSF 2010

## **1.2 Scope and process of the review and terms of reference**

A Serious Case Review was recommended by Rotherham Serious Case Review Standing Panel; which is a sub group of Rotherham Local Safeguarding Children Board (RLSCB) on 27<sup>th</sup> October 2010. A Serious Case Review (SCR) was then commissioned by the Independent Chair of Rotherham Local Safeguarding Children Board on 4<sup>th</sup> November 2010, in line with expectations of Working Together 2010.

A specific Serious Case Review Panel met on 18<sup>th</sup> November 2010 to consider the circumstances surrounding the sudden unexpected death of Child S a 17 year old girl in Rotherham. This Child had been known to a variety of universal, targeted and responsive services over a period of time.

At the time of completing this review the court proceedings related to her death have not taken place. In line with 8.26 Chapter 8 of 'Working Together to Safeguard Children' 2010 the Chair of the LSCB sought advice about progressing the SCR and determined that the court proceedings should not delay the review.

The specific Serious Case Review Panel requested that the following agencies/bodies secured their records and identified and commissioned an independent author of sufficient experience and seniority to undertake an Individual Management Review. Individual Management reviews were requested from the following agencies:

- Children's Social Care Services (includes Youth Offending Services)
  - Education services
  - RMBC Youth and Targeted Services (includes Project1 and Connexions)
  - GP Service
  - The Rotherham NHS Foundation Trust
  - Rotherham Community Health Services which includes:
    - School Nursing Services
    - Learning Disability Services
    - Community Paediatric Services
    - Safeguarding Children Health Team
    - Health Visiting Services
  - South Yorkshire Police
- (Please note that Rotherham Community Health Services from the 1<sup>st</sup> April 2011 integrated with The Rotherham NHS Foundation Trust but for the purposes of the SCR have been addressed separately except for the development of the action plan)

The authors of the Individual Management Reviews are independent in accordance with the guidance at 8.29 in Chapter 8 of 'Working Together to Safeguard Children' 2010 This states that: "Those conducting management reviews of individual services should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved"

## **1.3 Subjects**

The subjects of the review were identified by the Serious Case Review Panel on 18<sup>th</sup> November 2010 as Child S and Infant A .The Serious Case Review Panel felt that Adult B, mother of Child S,

records should not be reviewed as part of the Serious Case Review but that her involvement and engagement at the appropriate stage would be pertinent.

#### **1.4 Time Period**

The period of the review is 1st September 2008 until 12<sup>th</sup> October 2010.

#### **1.5 Terms of Reference**

It was agreed that the review should cover this period under Chapter 8 of Working Together 2010 this review is to:

1. establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
2. identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result;
3. was specific consideration given to ethnicity, religion, diversity or equality that were identified and required specific consideration; and as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

In addition, specific terms of reference have been identified for this case:

- The review will cover in detail the period from 1st September 2008 until 12<sup>th</sup> October 2010.
- A summary of agency involvement for the six years prior to this period (from September 2002) should be included in order to provide some history and context.
- The review should primarily focus on the immediate family of Child S and Infant A but examine any assumption by agencies that the maternal grandmother, Adult B was the primary carer for and protector of Child S's baby, Infant A and that this became the focus of interventions, losing sight of Child S, as a mother and as a young vulnerable person in her own right.
- To consider how services support young parents where there are known issues that can impact on parenting capacity including where the parent has a learning difficulty.
- How the parenting of Child S influenced her capacity and ability to protect herself and her baby Infant A.
- The quality and effectiveness of continued assessment of risk and interventions provided to Child S and Infant A, given the known history of sexual exploitative relationships and Child S's learning difficulty.
- The impact of the absence of information on significant adult males including the putative father of Child S.
- The effectiveness of inter and intra agency working in relation to communication, coordination and information sharing on young parents who are significantly in need, have additional vulnerabilities of their own that may impact upon their capacity to parent.

- Consider whether the decisions and actions taken by the agencies involved were in accordance with policies, procedures and relevant practice standards.
- The supervision of staff and the support provided in working with child protection and complex children in need cases in relation to their level of knowledge and experience.
- Any similarities with previous local Serious Case Reviews or national themes, their recommendations and subsequent actions.

## 1.6 Process

The author of the overview report, Professor Pat Cantrill, is a Registered Nurse and Health Visitor and was a senior civil servant at the Department of Health. As Assistant Chief Nursing Officer, (DoH England) for Clinical Practice and Regional Director of Workforce Development and Nursing, Pat developed leadership qualities and professional credibility nationally. She held two of the most senior nursing posts in the country, both of which have demanded a high public profile. She has also had considerable education experience, is a qualified teacher and has been a senior university lecturer, senior tutor/education manager and Governor at Sheffield College. Pat is a Visiting Professor at Sheffield Hallam University and the University of Lethbridge in Canada. She is a company director of her own limited company and is a Non Executive Director of Westfield Health Scheme.

Considerable discussion took place with Pat to ensure that there were no elements of the review that might conflict with her being the independent author of the report whilst also the Independent Chair of Rotherham Adult Safeguarding Board but as she has not had any contact with the children's services in any of the agencies we are reassured that there is no conflict of interest. Pat has led a number of high profile serious untoward incident reviews particularly in relation to safeguarding vulnerable adults and children. She has considerable experience in cases of sexual exploitation /abuse.

Her appointment is in accordance with the guidance at 8.20 in 'Working Together to Safeguard Children'.2010 which states that:

'the overview author should be independent of the local agencies, professionals involved and the LSCB. And that the person should not be the chair of the LSCB or the SCR subcommittee / panel'.

## 1.7 Membership of the Serious Case Review Panel:

Adele Jones	Service Manager, CAFCASS
Ailsa Barr	Service Manager, Safeguarding Children Unit
Catherine Hall	Nurse Consultant / Designated Nurse, NHS Rotherham
Deborah Wildgoose	Deputy Director of Nursing, RDASH
Eisawl Nagmeldin	Named Doctor, RFT
Sherif El-Reftee	Designated Doctor, NHS Rotherham
Doreen Hollingsworth / Beckie Marjoram	RMBC Solicitor

/ Robin Williams	
Howard Woolfenden	Interim Director of Safeguarding and Corporate Parenting, CYPS
Maryke Turvey	Head of Rotherham Delivery Unit, SY Probation Trust
Phil Morris	Business Manager, Rotherham LSCB
Sam Newton	Safeguarding Adults Manager, Neighbourhoods and Adults Services
Yvonne Weakley	Associate Director of Children and Young People's Services, RCHS
John Lambert	Consultant Headteacher, School Effectiveness Service, Children and Young People's Services

Professor Pat Cantrill attended panel meetings from 23 February 2011 as the overview author to observe but was not a formal member of the panel.

The meetings were chaired by independent chair Peter Williams.

Peter Williams is a qualified Social Worker holding a CQSW and MA in Social Work. . He is currently Head of Children's Services Organisational Development for Barnsley Metropolitan Borough Council where he has responsibility for strategic organisational and workforce development including children's social care. He has significant safeguarding experience having worked in a number of Local Authorities over a twenty year period as a social worker, team manager and service manager within statutory children's social work. This includes experience of working within the context of the Serious Case Review process.

The objective of the Individual Management Reviews (IMRs) that form the basis for the SCR, is to give as accurate an account of what originally transpired in an agency's response to the child and their family, to evaluate it fairly, and if necessary to identify any improvements for future practice. IMRs also propose specific solutions which are likely to provide a more effective response to a similar situation in the future.

This report is based on IMRs commissioned from professionals' independent from their commissioning agency. The report author has indicated whether there is confidence in the findings of an IMR.

The report's conclusions represent the collective view of the Serious Case Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

The Serious Case Review Panel has received and considered the following Individual Management Review Reports (IMR):

Author of The Rotherham NHS Foundation Trust IMR  
Carol Boote - Specialist Nurse, Child Protection, Rotherham NHS Foundation Trust

Author of the Health Overview Report  
Catherine Hall - Nurse Consultant, Safeguarding Children, NHS Rotherham

Author of the Youth and Targeted Services IMR  
Paul Grimwood - Youth Offending Services Manager, Children and Young People's Services,  
Rotherham Metropolitan Borough Council

Author of the South Yorkshire Police IMR  
Helen Smith - Sergeant, Public Protection Unit, South Yorkshire Police

Author of the Education Services IMR  
John Farrar - Independent Author

Author of the Rotherham Community Health Services IMR  
Kim Porteous - Senior Nurse Advisor / Named Nurse – Safeguarding Children, Rotherham  
Community Health Services

Author of the GP Services IMR  
Malcolm Swallow - General Practitioner, NHS Rotherham

Author of the Social Care IMR  
Peter Ward - Independent Author

In addition a comprehensive integrated family chronology of agency involvement and significant events from the period 1st September 2008 to 11th October 2010 has been compiled and analysed by the Serious Case Review panel. This document appears at Appendix One.

In reporting the views of individuals who received services, the Review Panel is not endorsing those views as accurate or as a fair assessment of the services they were given. They are the subjective views of the service user and should be considered with respect, in that they may offer lessons for the services involved.

## **1.8 Involvement of the family**

*Working together to safeguard children* 2010 recommends that serious case review panels should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'.

Child S' Mother Adult B, Sibling 3 and Child S's father were invited to contribute to the review. Adult B agreed to participate. Sibling 3 did not wish to participate. No response was received from other members of the family.

Adult B was interviewed by the report author in the presence of the Business Manager of Rotherham LSCB. The content of the report has been discussed with Adult B and her contribution approved.

The Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned. Discussions will take place about the publication of a redacted Overview Report.

An integrated chronology of events and an action plan have been submitted with the Overview report.

Following acceptance of this report by Rotherham LSCB, a confidential 'briefing note' encapsulating key messages and agreed recommendations will be circulated to relevant managers in each of the agencies that contributed to this SCR. This will be influenced by the criminal trial as some staff have to give evidential interviews.

## 1.9 Family Genogram

[Redacted content]

[Redacted content]

[REDACTED]

XxxxxXxxxxxxx xxx	Xxxxxxxxxxxxxxxxxx	XxxxxXxxxxx
XxxxxXxxxxxxx xxx	XxxxxxxxxxxxxXxxxxX	XxxxxxxxxxxxxxxxxXxxxxx
XxxxxXxxxxxxx x	XxxxxxxxxXxxxxX	XxxxxXxxxxx
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[REDACTED]

[REDACTED]

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[REDACTED]

## **SECTION TWO -THE CONTEXT OF SERVICE INVOLVEMENT**

***“A good child protection system should be concerned with the child’s journey through the system from needing to receiving help, keeping a clear focus on children’s best interests throughout. This includes developing the expertise and the organisational environment that helps professionals working with children, young people and families to provide more effective help.” Munro.<sup>2</sup>***

### **2.1. Setting the Context**

The purpose of this section is to provide an overview of the context which influenced the care provided to Child S and Infant A and changes that have occurred during the timescales of this Serious Case Review. It will enable assessment of the provision of services to take place with an understanding of the environment in which practitioners worked within the policy frameworks, organisational structures and professional practice from 2004 to 2010. It also addresses some terms of reference as an analysis of the performance of Rotherham’s Children’s Services is made and action taken considered.

### **2.2 Rotherham**

Rotherham has a population of 253,859. It contains a mix of urban areas and villages, interspersed with large areas of open countryside. Many of the challenges facing the Borough stem from the decline in the traditional coal and steel industries. This has resulted in massive changes within the local economy, changing jobs and businesses as well as the environment, communities and social conditions. As the public sector is a major employer of local people the impact of the present cuts in services will have a great impact on employment. Like many other areas Rotherham has an ageing population.

Deprivation in Rotherham is decreasing according to Communities for Local Government.

Rotherham was ranked 48<sup>th</sup> most deprived district in England in the 2000 Index, and ranked 68<sup>th</sup> in the 2007 index; however this is still amongst the top 20% most deprived districts in the United Kingdom.

The Borough’s population includes 59,489 children and young people aged 18 years or under, of which 21% are aged 0 to three years. At January 2010 the proportion entitled to free school meals was 18.7% which is above the national average. Children and young people from minority ethnic groups account for 14.1% in primary schools and 10.9% in secondary schools. The percentage of pupils who speak English as a second language has increased slightly from 7.2% in 2009 to 7.9% in 2010.

The gender split for children and young people in Rotherham has remained constant since the model was produced in 2003. The figures for 2008 were 51% male, and 49% female. Local birth statistics suggest that Rotherham’s birth numbers have been increasing slightly each year since 2000, from 2527 in the 2000/01 academic year to 3381 in 2006/07; birth rates in 2009/10 averaged 2800. Rotherham, like many areas across the UK, has a significant number of children and young

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<sup>2</sup> The Childs Journey. Interim report. Munro 2011

people living in deprived areas; 14.2% of all Rotherham children live in areas which are within the 10% most deprived nationally (using the Index of Deprivation Affecting Children (IDAC) 2007) and 31% of children who live in low income households live in the 10% most deprived areas nationally. Since 2008, the percentage of local children at risk has increased and is now higher than national figures across all three main categories of concern; Children in Need, Looked After Children and Children with a Child Protection Plan. There are 292 children and young people subject to a child protection plan with 17 of these being looked after children. The leaving care service currently works with 188 care leavers. Care leaver services are commissioned from Action for Children.

Rotherham has 99 infant, junior or primary schools, 16 secondary schools and six special schools. There are six pupil referral units with one shortly to be deregistered. There are 23 children's centres.

Rotherham's minority ethnic population is 3.1% which is below the national average. The majority of Rotherham's Black and Minority Ethnic (BME) population is concentrated in four central wards; Boston Castle, Rotherham East, Rotherham West and Sitwell, this has not altered between 2005 and 2007. In Rotherham South there is a large and growing BME population, based on school pupil data (2005 compared to 2008). The link between an increase in the birth rate and the growth of the BME population is also shown in 2001 Census data, where Rotherham South has the highest number of people living in families with two or more dependent children, with Rotherham East and Boston Castle wards being the two highest wards overall in terms of those families with two or more children and BME school pupils. More recently, there has been a significant increase in the arrival of EU migrants to the Borough. In the school year beginning in September 2008 there were 375 new arrivals of school-age children, 58% (204) of whom were of Roma heritage. School registration data suggests that more families have arrived in the 2009/10 school year than in previous years. More than 400 Slovakian Roma children have arrived in the school year that began in September 2009.

The health of the people of Rotherham is generally worse than the England average. Life expectancy, deaths from smoking and early deaths from cancer are worse than the national average. Teenage pregnancy rates are worse than the national average.

## **2.3 The Safeguarding System**

Safeguarding children and young people has been defined as;

All agencies working with children young people and their families taking all reasonable measures to ensure that the risk of harm to children are minimised and where there are concerns about children and young people's welfare all agencies taking appropriate action to address those concerns working to agreed local policies and procedures in full partnership with other local agencies<sup>3</sup>

Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are experiencing, or are likely to suffer, significant harm. Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. All agencies and individuals are expected to proactively safeguard and promote

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<sup>3</sup> The 2<sup>nd</sup> Joint Chief Inspectors' report on arrangements to safeguard children 2005

the welfare of children so that the need for action to protect children from harm is reduced. Early intervention is crucial to ensuring the best outcomes for children and young people where their safety is an issue.

Since March 2004 there have been more than 40 key Government legislative or policy documents the most significant being the Children Act 2004, which sets out very clearly the requirements placed on those who provide services for children, to work together to promote well being and safeguard children and young people. It introduces the concept of '*Making safeguarding everyone's business*'. This means that services provided have to be structured to meet the needs of children and young people and to ensure that they are afforded '*protection from risk of significant harm*' as defined by the 1989 Children Act.

Recent reports that influence this review has been undertaken by Lord Laming "*The Protection of Children in England: A Progress Report (March 2009*" and the Overview reports resulting from the death of Baby Peter Connolly.

The overview report has also been influenced by the appraisal of child protection services being undertaken for the Coalition Government by Professor Eileen Munro. Two interim reports have been available and have been used. The final Munro report will be published in May 2011 and will have consequences for the development of safeguarding children and young people in Rotherham.

The main government guidance for safeguarding and protecting children is *Working Together to Safeguard Children*. When it was revised in 2006 and again in 2010 every local authority was required to update their local procedures in the light of any revisions made. It recognises that there is a spectrum of risk to children and that in some instances children will need to be removed from the care of their parents, even permanently.

Safeguarding and promoting the welfare of children is the responsibility of Local Authorities (LA's), working in partnership with other public agencies, the voluntary sector and children, parents and the wider community. A key objective for LAs is to ensure children are protected from harm. The Children Act 2004 firmly places duties on LAs, to safeguard and promote the welfare of children and young people. Every Child Matters and the National Assessment Framework for Children, Young People and Maternity Services additionally provide drivers for change, providing timetables for action for organisations and service providers. A challenge for LAs is to ensure that their partner organisations providing universal services prioritise safeguarding when the targets they are given to achieve do not.

The present framework for safeguarding children in Rotherham during the period of involvement with Child S reflects the implementation of the Children Act 2004 and the Every Child Matters programme and as a result led to:

- The appointment of Strategic Director, Children and Young People's Services (DCS) and designated Lead Members for Children's Services. The DCS is professionally accountable for the delivery of authorities' education and social services functions for children, and any health functions for children delegated to the authority by an NHS body.
- Rotherham Local Safeguarding Children Board has in place an Independent Chair. This facilitates greater independence in chairing and reporting and a focus on a wider safeguarding role in addition to child protection and providing leadership.

- Strategic partnerships for delivering services to safeguard and promote the welfare of children have been established. Agencies are working together better to safeguard children. Every Child Matters has provided a coherent framework for joint working although some partners are stronger than others. As identified in the Ofsted report 2008 <sup>4</sup> locally as well as nationally there remain areas for improvement, many associated with joint commissioning of services for all children in need.
- The Common Assessment Framework (CAF) has been developed to support an integrated approach to meeting the needs of children<sup>5</sup> who fall below the statutory threshold of Section 17<sup>6</sup>. Its use is gradually being embedded in practice by social care and universal services, and addresses problems before they become serious, therefore improving outcomes for children. There is little evidence in this Serious Case Review and the IMRs to support the fact that the CAF is being used as a more effective consistent assessment processes which improves in the quality and consistency of referrals, the establishment of a common language about the needs of children and appropriate sharing of information supporting more effective interagency working.
- The Framework for the Assessment of Children in Need and their Families should be used to establish an inter-agency model of assessment and service provision again there is little evidence of this being applied to the care of Child S and Infant A.
- Family support initiatives operate across a range of partner services with early intervention and prevention being undertaken in the Family Intervention Project (FIP) team and through Families and Schools Together (FAST).

## **2.4 Rotherham Children and Young People's Plan**

The Strategic Director, Children and Young People's Services has led the development of the Rotherham Children and Young People's Plan (CYPP). The plan reflects the core requirement of Local Authority services for children and young people and the involvement of local partners across the whole range of services for children and young people providing a framework for coherent and comprehensive planning and service delivery.

Rotherham's third Children and Young People's Plan (CYPP) 2010 -2013 identifies a 17% increase in the number of children in care compared with 2% nationally. It also notes that this, and the 23% rise in the number of children who have child protection plans, have increased demands on the service.

As overview author I have reviewed the CYPPs for 2007 to 2010 and the new plan for 2010 to 2013. Whilst the 2007 CYPP addresses many of the key issues and targets required both nationally and locally the Ofsted inspections outlined above indicate that the vision and values and targets set were difficult to achieve. In the 2010-2013 plans there is a review of what was achieved during 2007-2010 which included:

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<sup>4</sup> Safeguarding Children The third joint chief inspectors' report on arrangements to safeguard children

<sup>5</sup> Every Child Matters: Stay safe, be healthy, enjoy and achieve, make a positive contribution and economic well being.

<sup>6</sup> Children Act 1989. Section 17. Statutory threshold "Child in Need".

- The Local Safeguarding Children Board has been strengthened with the appointment of a new independent Chair and revised representation.
- A local councillor has been identified for Safeguarding for each Area Assembly in the Borough.
- A new Serious Case Review process to ensure robust partnerships is in place.
- A new performance reporting system has been introduced to monitor individual cases and worker caseloads.
- Common standards relating to safe recruitment practices are in place across all partner agencies.
- Dedicated children and young people police officers are now placed with locality teams and this has helped early intervention work.
- The Safeguarding Children Service Unit works closely with the police to monitor individuals assessed as presenting high risks to young people.
- New inter-agency guidance is in place to ensure an appropriate response to Domestic Abuse and the new Domestic Violence Priority Group is driving this forward.
- Partners are now based together in an integrated Safeguarding Service Unit to improve joint working and information sharing.

Some of the above developments are already achieving improvements whilst others are still to fully impact on services and outcomes for children.

The 2010 -2013 CYPP plan has far more rigour and clarity regarding not only what, and how the vision and targets will be achieved but also addresses the performance management, assurance and accountability and responsibility issues that should enable the CYPP to be more successful. The CYPP for 2010-2013 has a clearly identified vision and has what it calls four big things



The focus is on *identifying need and supporting children, young people and families at the earliest possible stage*. There is a shift in emphasis to a prevention and early intervention. Each 'Big Thing'

has its own strategic plan for example; Prevention and Early Intervention Strategy, 'Transforming Rotherham Learning'. (Both areas are lessons to be learned from the care of Child S). The plan is an excellent example of a Children and Young People's Plan. Children and young people and the wider population have been involved in a consultation process. This identified the concerns that children and young people have for their safety for example 23% of young people say they never feel safe in the town centre or when they are out on their own.

The priorities in the plan<sup>7</sup> are for the partners to:

- *To improve the safety and security of vulnerable children and young people was the priority that received the highest response in the consultation; both children and adults believe that keeping children safe must come first.*
- *Domestic Violence was also an issue that many people who responded to the consultation felt strongly about. Vulnerable groups of young people are particularly concerned about this issue.*
- *Safeguarding children and young people is a priority for every partner and individual and plans for each institution need to be in place. We need to ensure that our response is fully coordinated with appropriate multiagency protocols for action and information sharing; embedding the use of the Common Assessment Framework will be central to this. E-safety is a rapidly developing issue.*

The outcome of recent joint inspections is also outlined in the plan and was included in the development of the CYPP 2010 - 2013:

- *We need more permanent social workers, social work managers and health visitors to work with children and young people in Rotherham. We have launched a new social worker recruitment website and are hoping that early interest in the website will be sustained.*
- *We need to improve the percentage of Initial Assessments that are carried out within ten working days, and Core Assessments carried out within 35 working days at the same time as maintaining and improving the quality of these assessments.*
- *We need to do more work to embed the use of the Common Assessment Framework in practice across children's services.*

It is not going to be easy for the Children's Trust to implement the plan effectively given the financial expectations and restructuring of all partner organisations.

## **2.5 The Performance of Rotherham Children's Trust**

Under section 20 of the Children Act 2004 a process of inspection by Ofsted and the Health Care Commission has changed to joint inspection of safeguarding and looked after children within the wider Comprehensive Area Assessment.<sup>8</sup> A new framework and guidance for inspections of contact, assessment and referral arrangements for children and young people in need and children

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<sup>7</sup> Children and Young People Plan 2010-2013 Rotherham Children's Trust

<sup>8</sup> For further information, see: <http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=63FF7DFA-D1DB-46D0-B72E-39DA12AEF9E1>.

and young people who may be in need of protection was introduced in 2009<sup>9</sup>. This focuses on evaluating outcomes for children and young people and the impact that practice and services have on improving outcomes. This was amended in September 2010 resulting in all local authority areas having an unannounced inspection of contact, referral and assessment arrangements in any one 12-month period.<sup>10</sup>

It is useful to examine the outcome of the joint reviews for Rotherham during the period 2008 to 2009 as it provides an independent assessment of the performance of childrens services and the context in which partnership organisations and practitioners were working.

In 2008 performance assessment of services for children and young people in Rotherham Metropolitan Borough Council 2008 identified that the contribution of services to improving outcomes for children and young people was adequate. The Ofsted report identifies in relation to safeguarding that the Childrens Services analysis of its strengths and areas for development underestimated a number of important weaknesses and overvalue the areas where progress has been made. However, it also identified that a higher percentage of initial and core assessments are completed on time when compared to statistical neighbours and the national average. The capacity of the services to improve, including its management of services, was assessed as adequate.

The assessment also acknowledges developments that had been made with recent redesign of services to develop greater partnership working which was a priority for the council and that the results of the changes had not yet fully impacted on services. The assessment also acknowledges the achievements made in enabling children and young people to make a positive contribution, levels of participation in and achievement of the Healthy School award. Fewer schools in the Borough were in an Ofsted category of concern following inspection than the national average with none subject to special measures. The proportion of care leavers and young people with learning difficulties and/or disabilities in employment, education or training were identified as high.

In December 2009 Rotherham Children's Services were under notice to improve having been judged by Ofsted to be performing poorly in the children's services annual rating. This was a result of the findings of an unannounced inspection contact, referral and assessment arrangements which had been carried out by Ofsted in August 2009. In addition there were significant problems recruiting suitable staff which resulted in there being several vacant posts within locality teams and a number of social work and team manager posts being occupied by short-term agency staff. National performance measures identified that the very large majority of outcomes were in line with the averages for England or for similar areas.

The assessment particularly highlighted that:

- *The wide range of work undertaken by social workers in localities undermines their capacity to deliver effective services to safeguard vulnerable children.*
- *Performance management systems and auditing policies do not ensure that local and senior managers are able to fully exercise their decision making and supervisory responsibilities in respect of contact, referral and assessment processes.*

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<sup>9</sup> *Unannounced inspections of contact, referral and assessment*, Ofsted, 2009; [www.ofsted.gov.uk/publications/090026](http://www.ofsted.gov.uk/publications/090026).

<sup>10</sup> *Unannounced inspections of contact, referral and assessment* Ofsted 2010

- *Information systems do not appear to provide up to date and accurate information on all contacts and referrals and the status of investigations, assessments and plans. Reduced email ‘in box’ capacity for managers adversely affects the timely and appropriate transfer of case information on vulnerable children.<sup>11</sup>*

An inspection of safeguarding arrangements and provision for looked after children in July 2010 graded the services as satisfactory and noted a number of improvements. The overall services were graded as adequate. Ofsted also commented that:

- *A minority of types of services, settings and institutions inspected by Ofsted were rated good or better.*
- *Five of the six special schools were identified as outstanding. Two-thirds of primary schools perform well although a few schools are inadequate.*
- *Some services and in Ofsted’s view too many were only satisfactory, for example pupil referral units, the sixth form college and nearly half of childminders and secondary schools.*
- *The local adoption agency was assessed as good but the local fostering agency and all the children’s homes for those in care are only satisfactory.*
- *Results in national tests were below similar areas for 11-year-olds and comparable with other areas at the age of 16.*
- *Gaps in achievement for pupils with special educational needs remained too wide*
- *Results continued to improve for 19 years olds from low income families gaining qualifications and were similar to those in other areas.*
- *The children with disabilities specialist team undertook contact, referral and assessment responsibilities effectively.*
- *Performance in respect of the completion of initial assessments and core assessments was inconsistent and often significantly delayed.*
- *The level and quality of formal supervision was considerably below that stated in the council’s supervision policy.*
- *The initial response to contacts across the localities was variable with a high level of ‘no further action’ decisions being taken.*
- *There is no evidence, from the cases seen, that the use of the Common Assessment Framework (CAF) was having significant impact.*
- *The quality of case planning, reviews and recording, including for children in need cases, was inadequate.*
- *Although practice was of an adequate standard overall, there remained some inconsistency in the work of social care teams.*
- *Recent data show improvements in the stability of placements for children in care and in the number of meetings to review plans for them. Children are generally safe within the community, and the number of admissions to hospital because of deliberate or accidental injury has reduced more than the national figure.*

The above list and the comments made by inspectors regarding safeguarding reflect those identified in the IMRs and are discussed further in Section 3. An inspection of safeguarding arrangements and provision for looked after children in July 2010 reported that services were satisfactory and noted a number of improvements which included that:

- *The local authority has taken strong corporate action to bring about improvement.*
- *Performance management and arrangements for quality assurance had improved*
- *That there was evidence of good multi-agency partnership arrangements noted in the inspection of front-line child protection services. This was confirmed by the full inspection.*
- *Capacity for improvement was judged to be adequate.*

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<sup>11</sup> Annual unannounced inspection of contact, referral and assessment arrangements within Rotherham children’s services August 2009 Ofsted

- *A number of new appointments have been made to strengthen senior management*
- *There has been successful work to recruit and retain staff, although staffing levels for social workers continue to be a challenge*
- *More work is needed to meet the training and development needs of staff.*

## 2.6 Performance Management

**‘A concern with doing things right versus a concern for doing the right thing.’ Peter Drucker (2000<sup>12</sup>),**

Lord Laming published *The Protection of Children in England: a Progress Report*<sup>13</sup> on 12 March 2009. In the report he confirmed that robust legislative, structural and policy foundations for safeguarding had been established. However Lord Laming called for ‘a step change in the arrangements to protect children from harm’ and, when looking at the performance management system, stated that:

*“The performance indicators currently in use for the safeguarding of children are inadequate for this task.”*

Lord Laming found that the existing safeguarding and child protection indicators were too focused on processes and timescales and not focused enough on outcomes and multi agency working.

Performance indicators alone are of course only one aspect of what must be available and considered when trying to ascertain the effectiveness and impact of a service to protect children and young people and adults. This matter is recognised by the Munro Review which is examining how local systems can change. The Munro Review will reflect on how this approach can result in the required improvement in practice that has not resulted from past changes in arrangements to protect children from harm.

There are a number of developments that will influence the collection and availability of standardised data:

- The Government’s Coalition Agreement
- Children in Need census
- ChildONEurope Guidelines on Data Collection and Monitoring Systems on Infant Abuse
- UN Convention on the Rights of the Child places emphasis on good data collection systems.
- Section 11 data required from Working Together to Safeguard Children. Section 11 of the Children Act 2004 is accompanied by statutory guidance on making arrangements to safeguard and promote the welfare under Section 11 of the Children Act 2004 for local authorities and all organisations providing direct services to children.
- ADASS review of data collection for adult safeguarding.

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<sup>12</sup> The Effective Executive: The Definitive Guide to Getting the Right Things Done P Drucker 2000

<sup>13</sup> Protection of Children in England: a Progress Report<sup>13</sup> Laming 2009

The aim is that the work completed by the Children in Need Census and the Munro Review will result in a single comprehensive reduced and refocused set of data collection requirements that would capture the minimum information needed to run effective children's services. Munro identifies that this will be made up of two essential components; a core of data collected by central Government and recommended discretionary data, which will be published by local areas in a standardised form to enable benchmarking, comparability and public accountability.

Many of the organisations in Rotherham have been developing new information management systems. In health care the move has been towards SystemOne. GPs use a variety of systems but a pilot has been established to provide access to SystemOne. Staff at the Rotherham Foundation Trust can get access to SystemOne.

Rotherham Metropolitan Borough Council (RMBC) Childrens Social Care uses SWIFT information system and South Yorkshire Police Service use national IT systems. The systems do not interconnect and this influences the speedy exchange and access to information. Rotherham also used Contact point to find missing children which proved useful particularly for families crossing geographical borders.

*'The single most important change in the future must be the drawing of a clear line of accountability from the top to the bottom without ambiguity about who is responsible at every level for the well being of vulnerable children' (Laming Report, 2003<sup>14</sup>, para.1.2).*

As part of the CYPP 2010-2013 clarity is provided about the governance structures and processes established. In Rotherham as part of the CYPP 2010-2013 each quarter the Children and Young People's Board receives a performance management report with an indication of the direction of travel for each indicator. Where the direction of travel is not positive Performance Clinics are used to identify issues and solutions. The action plans form an integral part of the Performance Clinic process. Planning and activity is re examined and re-focuses services where necessary. The findings are then reported back to the Children and Young People's Board.

Rotherham's Children and Young People's Board was established in 2006, along with the Children and Young People's Strategic Partnership. Both of these have been reviewed recently and were replaced by the Children and Young People's Trust Board (CYPTB) in April 2010.

A formal protocol governs the relationships between the CYPTB and the Rotherham Local Safeguarding Children Board (RLSCB). The Strategic Partnership has now become the Think Family Board and this represents the wider partnership working at a strategic level. Other significant changes that should improve multiagency working are:

- A multi-agency safeguarding service unit is centrally based and there is a separate safeguarding team that supports the RLSCB.
- Children's social care is delivered through three locality teams which include co-located health staff, youth workers and police officers. Plans are well advanced to modify this structure to increase the focus on safeguarding, corporate parenting and performance management. Fostering, adoption and services for children with disabilities are delivered on

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<sup>14</sup> The Victoria Climbié Inquiry report of an inquiry by Lord Laming 2003 DoH

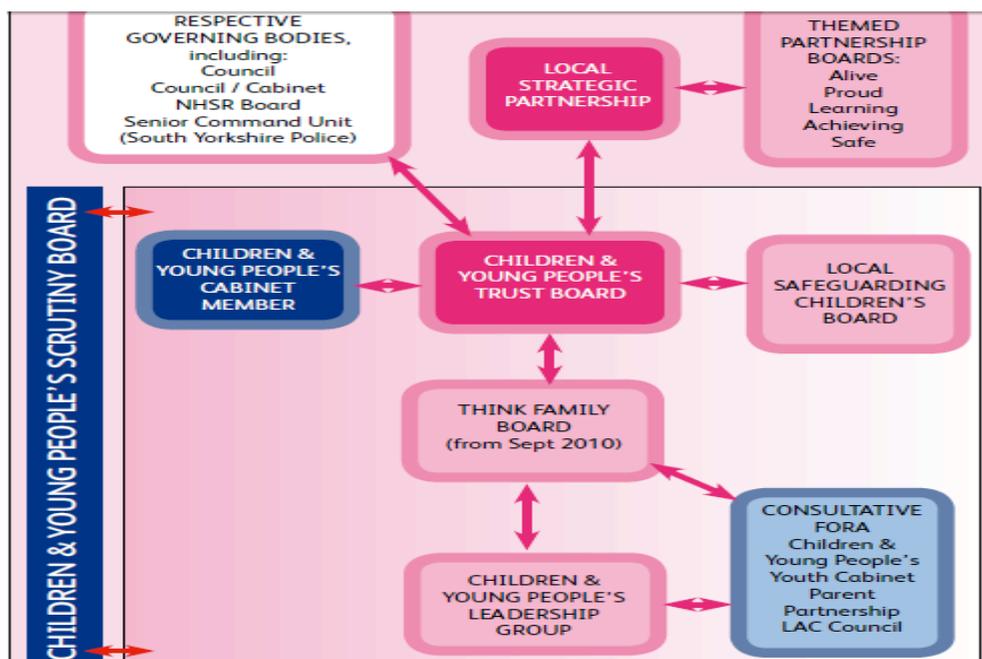
a borough-wide basis. There is also a Borough wide Looked After Children Team which focuses on long term Looked After children and Permanency Planning.

- Specialist support teams from January 2011 have been developed to meet the needs of children and young people with specialist needs such as Child S. They include: Learning Disability services, Complex Health Care team, Children and Adolescent Mental Health Teams, Allied Health professionals (including Occupational therapy, speech and language therapy, Physiotherapy) and Looked After Children's Services. They will engage in each locality with the police, Area partnership managers, GPs, schools, voluntary and community agencies, fire and rescue services and all other providers to plan and prioritise services for children and young people. The same processes and systems will be used across multiagency teams to support coherent practice. The CAF and the role of the lead professional will be critical.
- Another development is The 'Better Together' Programme which will: -
  - Lead the change in focus of services from 'find and fix' to 'predict and prevent'
  - Strengthen collaborative leadership
  - Stimulate effective leadership within multi agency work
  - Establish Learning Community wide priorities and action by key leaders
  - Develop a strategic forum to respond to the emerging localisation agenda
  - Engender collective responses that flex and adapt to changing circumstances within the Learning Community
  - Build capacity and nurture responsibility for the achievement and well being of all young people across the Learning Community
  - Engender effective communication and the sharing information at a leadership level
  - Encourage leaders to inspire and support their workforce to work with partners
  - Drive organisational change and encourage risk taking and innovation
  - Support the collaboration of services and agencies around issues of mutual local interest
  - Support the move from bonding to 'bridging' the different cultures that exist between professionals
- 16 Learning Communities have been established which are said to; provide *coherent and progressive pathways for each and every learner; building upon best practice from innovative Integrated Services Pathfinder Projects. The ambition is for each Learning Community to fully embrace the strategy for children, young people and families, extended, life-long learning and the development of really effective Prevention and Early Intervention strategies. It is intend to transform the way in which learning happens in Rotherham. Each of the learning communities will be challenged to build a partnership that better connects primary, secondary and special schools with children's centres, colleges, other providers and users to ensure ambitions are realised through effective partnerships at a local level. Life chances should be transformed by determining strategies to enable early intervention, improve literacy and numeracy and forge integrated approaches to moving 'stuck' children and families.*
- Planning and commissioning of health services for children are led by the council and NHS Rotherham (NHSR), the latter of which commissions acute hospital and maternity hospital services from The Rotherham NHS Foundation Trust. Rotherham Community Health

Services (RCHS) are commissioned by NHSR to provide children and young people's community health services (including health visiting and school nursing), are co-located with council services in locally based communities and schools. NHS Rotherham are the lead commissioners of Child and Adolescent Mental Health Services (CAMHS) services which are provided by Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH), Rotherham Community Health Services, Rotherham Mind (Third Sector not inspected here) and Sheffield Children Hospital (in-patient mental health services not inspected here). The council commissions specific therapeutic services for looked after children. This approach will be influenced by the changes that are part of the Coalition Governments reconfiguration of health services. At the time of writing the report a national consultation exercise is taking place concerning the changes but the plan is that NHS Rotherham will be replaced in 2013 by GP commissioning Groups.

## 2.7 Rotherham Children's and Young Peoples Services Governance Structures

The organisational diagram below identifies the corporate governance structures that are now in place to support the coherent development and performance management of children and young people's services.



## 2.8 Workforce Planning

Following reports of the death of Baby Peter Connolly in late 2008 and the subsequent SCR published in February 2009 by Haringey Local Safeguarding Children Board, there was intense scrutiny in Rotherham about the role, function and fit-for-purpose nature of children's social work. The Government at the time requested that an urgent progress review of child protection be undertaken in England, and the Social Work Task Force & Children's Workforce Development Council were commissioned to deliver urgent recommendations for improvement and interventions to help deal with a national crisis where 1 in 7 children's social work posts were reported vacant<sup>15</sup>.

This is said to have been felt acutely in Rotherham. At a time when Children & Young People's Services (CYPS) and the Local Authority was in the process of integrating services with Health and other partners, rising vacancy factors placed significant pressures on fieldwork social work services. As these pressures continued to mount, so vacancies escalated, until the Ofsted inspection findings led the Government to issue CYPS with a Notice to Improve in November 2009. Despite this being the lightest Government intervention possible, this proved to be a turning point for CYPS.

This feeling of pressure on social workers can be identified in the Child S SCR and the changes that are identified should help to address the ability of Social workers to provide the required planning, direct work and monitoring of clients.

At the time the Notice to Improve was served, there were vacancy rates in the region of 37% in front line social work posts, and in the region of 54% in team manager posts. Additionally, there were vacancies in Service Manager positions, and the Director of Safeguarding & Corporate Parenting post was being undertaken by an interim post holder. There was no strategic approach to PQ at the time, and many of the experienced social work staff had either retired or moved on to other employers.

Under the direction of a Corporate Improvement Panel chaired by the Chief Executive of RMBC, many initiatives were instigated to help improve the quality of social work practice in CYPS and reduce the vacancy factor rate in line with Department for Education targets.

What took place over the resulting 12 month period was a wide range of interventions which saw CYPS exceed Government targets and significantly improve the practice of safeguarding children and young people, work which was recognised in the "adequate" judgement in the summer of 2010 following the 10 day announced Ofsted inspection.

Firstly, a PQ strategy was put in place which allows for every qualified and practising social worker in CYPS (in the region of 100 members of staff) to have access to the University of Sheffield's MA in Professional Practice, an innovative way of working with a high quality Higher Education Institution to commission the right people to provide children's social workers with the right skills to do the challenging work they need to.

Using Children's Workforce Development Council (CWDC) monies and local expertise, both Newly Qualified Social Worker (NQSW) and Early Professional Development (EPD) programmes were put in place to help develop NQSWs and ensure that staff that have been qualified for less than 2

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<sup>15</sup> BBC News, 3 February 2009, at [http://news.bbc.co.uk/1/hi/uk\\_politics/7866827.stm](http://news.bbc.co.uk/1/hi/uk_politics/7866827.stm)

years get a well structured and high quality learning and development programme to support their practice. CYPS led regionally on the roll out of a Return to Social Work programme in 2010, helping to support existing social workers back into the workforce. Pioneering work around Practice Education and the early development of Service Level Agreements with HEI partners saw a high calibre of NQSWs employed in September 2010, many of which had previous experience of working on placement in Rotherham

By September 2010, 2 fulltime equivalent Social Work Practice Consultants were employed in the Workforce Planning & Development Service to lead on “grass roots” service improvement across teams, helping to reshape local processes and working practices to ensure practitioners had a voice and influence on the way they work.

Running parallel to this investment was the restructure of CYPS social work structures under the direction of the recently appointed Director of Safeguarding & Corporate Parenting with 7 multi-agency localities being reorganised into 3 social care service areas, each with its own qualified social work service manager overseeing provision. A borough wide “Looked After Children” service was also established at this time, to help alleviate workloads in fieldwork teams and provide the right kind of specialist service to best support children and young people. Also, all social workers and managers were issued with a Virtual Private Network token to support flexible working.

Additional plans were also approved to use CWDC Social Work Improvement Funding to employ 4 fulltime equivalent Social Work Practice Consultants in fieldwork teams, posts which will be non-caseload carrying and which will carry the brief to help develop NQSWs and support other inexperienced staff. These posts have been developed in line with recommendations made by the Social Work Task Force, and it is planned to substantiate them beyond the point the grant funding expires. The Munro Review will influence how these posts could be used in the future. The staff will commence in June 2011.

Having an effective reward package in place; offering high quality accredited learning and development to all social workers; working collaboratively with staff and giving them voice and influence over the systems they have to work with; creating and appointing to posts with a specific brief to help social workers make the tough decisions and practice reflectively: all of these interventions appear to have helped CYPS to be one of the first Local Authority departments to be removed from intervention at the original expiry date. Further improvements are needed and are taking place, but CYPS is no longer losing social workers and is now instead operating with a healthy turnover level. Of the 11 vacant posts in fieldwork services as of 1<sup>st</sup> April 2011, 9 have staff confirmed as coming into them. Whilst a vast proportion of the workforce has been qualified for less than 5 years, they appear to be a well supported staff group who are committed to working in Rotherham. There is a commitment to continue to deliver on the expectations of the Social Work Reform Board and the final report of Professor Eileen Munro, and expressions of interest have already been made to the new College of Social Work to share the work that has been done and help them develop.

Lord Laming stated<sup>16</sup> that the cornerstone of safeguarding practice is supervision. The IMRs identify that there were problems in relation to staff gaining or appreciating the value of supervision. The Ofsted inspection in July 2010 identified that supervision is now taking place regularly for most social workers and is in line with the supervision policy. However, the comment

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<sup>16</sup> Protection of Children in England: a Progress Report<sup>16</sup> Laming 2009

was made in the report that it is predominantly focused on case management and insufficiently focused on constructive challenge, development and support. Health professionals report good safeguarding supervision with increasingly flexible approaches which include some joint supervision with social workers.

## **Safeguarding Training**

The Government publishes statutory guidance for agencies and LSCBs in regard to safeguarding practices. In the most recently published documentation Working Together to Safeguard Children 2010 safeguarding learning and development levels are divided into 8 categories, called groups.

Rotherham LSCB has produced a Learning & Development Prospectus 2011 -12 which describes the learning opportunities that are available for levels 3 – 6 .Levels 1 and 2 are a single agency responsibility. Groups 7 and 8 relate predominantly to LSCB members or other Board members.

RLSCB quality assures the learning experience and access to training by the use of arrangements to safeguard and promote the welfare of children section 11 children act 2004 self assessment tool. Training is mentioned in Policy Statement 5 which is specific to training but it is also included in other standards. Whilst this audit comes from the LSCB, NHSR have also monitored compliance and each Provider Trust and NHSR had to work on 3 priorities which have been followed up in the Safeguarding Health forum. The LSCB is in the process of recruiting a Quality Assurance Officer to monitor performance.

Additionally, safeguarding training in health organisations has been evaluated by the Designated Nurse in all provider health trusts to ensure that it meets Working Together 2010 and Intercollegiate expectations. Each Trust was given feedback and an action plan to ensure that any gaps were rectified. Providers were able to demonstrate compliance.

The IMRs identify that generally the professionals involved in the care of Child S and Infant A had undertaken appropriate safeguarding training.

## **2.9 National Health Service Organisational Changes**

Like many other public services the NHS since 2004 has been through a considerable amount of change with Government initiatives influencing legislation, policy and structural changes. A major issue for partnership development, interagency planning, working and service delivery is the frequent reorganisation and mergers of organisations and in some instances resultant changes in functions and responsibilities and key personnel. The Coalition Governments is reorganising the NHS again. The result of this in Rotherham has been that the:

- Transforming Community Services (TCS) is a change programme established by the Labour Government to change the delivery of community health care services to help meet new requirements in commissioning health care. Central to its focus is the separation of Primary Care Trusts' (PCTs) commissioning and provider functions. On 1<sup>st</sup> April 2011 the Community Services in Rotherham integrated with The Rotherham Foundation Trust. This provides an opportunity to integrate services across acute and community care proving coherent care pathways.

- Presently until 2012 Rotherham Health services are accountable to NHS Yorkshire and Humber (SHA). After this date the health services will be accountable to new structures being developed as part of the Coalition Governments structural changes to the NHS. Under Section 11 of the Children Act 2004, Strategic Health Authority (SHAs) have statutory responsibilities to safeguard and promote the welfare of children & young people. The (SHA's) role is to performance manage and support the development of NHS and Primary Care Trusts' arrangements to safeguard and promote the welfare of children and young people. The SHA will manage performance against the core and developmental standards and Trusts' implementation of child protection serious case review action plans.
- NHS Rotherham presently commissions health services for the population of Rotherham. With a budget of £436 million and are responsible for planning and delivering health services and ensuring that local hospital services and specialist treatment are available for local patients who need them and that they offer value for money. PCTs also commission a number of services from GP practices, opticians, pharmacists, hospital trusts, and mental health care services, independent and voluntary providers. PCTs are accountable for their own child protection structures and processes as well as for those in agencies from whom they commission services. The Coalition Governments changes to the NHS plan to remove PCTs in 2013 and replace them with GP Commissioning Groups. In Rotherham it is called the Commissioning Executive and it is one amongst 177 consortia across the country who have been awarded pathfinder status and have taken responsibilities as part of the Government's plans set out in the NHS White Paper 'Liberating the NHS: Equity and Excellence'.
- The Rotherham Foundation Trust is accountable to an independent corporate body called Monitor. This is responsible for authorising, monitoring and regulating NHS Foundation Trusts. The Rotherham NHS Foundation Trust is rated as excellent for the second consecutive year. The Trust received a rating of good in 2006/07 and fair in 2005/06. Maternity services rated as better performing.

### **General Practitioner Services**

Lord Laming in *The Protection of Children in England* identifies the challenge of engaging GPs in Children's Trusts, Local Safeguarding Children Boards, and other multi-agency forums for safeguarding children. He states that '*It appears that the safeguarding of vulnerable children is often not viewed as a priority for GPs in some areas*'.

General practitioners are not directly employed by the NHS. Rather, they provide services to their local NHS commissioning organisation, under the terms of a national contract. There is very limited discretion to vary the terms of this contract. General practitioners employ their own staff e.g. practice nurses, receptionists etc. As a result Primary Care Trust's and their predecessor organisations have limited powers in relation to the management of performance of GPs and their practice staff as they are independent providers of services and not employees of the PCT. Involvement in safeguarding and child protection does not form part of the contract with GPs and therefore does not attract the same incentives as the provision of other areas of care..

General Practice is the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. However, General Practice has changed significantly in the last decade. The traditional practice where one or two practitioners know all their patients, and their extended families, is disappearing. Moves towards larger practices with part-time and/or salaried clinicians, a range of service providers (e.g. GP Out of Hours Services, Walk-in Centres, and GP-led Health Centres) has tended to fragment the knowledge base and continuity of care. It is therefore critical that communication and record-keeping is robust and meticulous.

Providing primary care services in an area of social deprivation to a population with complex health and social care needs is a challenge. It is because of this complexity that GPs need to have in place the structures that support their practice. Providing health care to a population that may have a diminished regard for individual and public health necessitates a multidisciplinary team approach where sharing of information and joint assessments are key. There is evidence in the case of Child S that the required level of information sharing between health professionals and subsequently with other agencies was not achieved.

There is evidence that GPs in Rotherham recognise the importance of their role in safeguarding children and young people as they have prioritised safeguarding as part of their Protected Learning Time.

## **Public Health**

The implementation of '*Healthy lives, Healthy people*' the Coalition Governments consultation document for a new strategy for Public Health will see the Public Health function moving to Rotherham Metropolitan Borough Council.

## **Getting it right for Children and Young People**

The DoH commissioned Sir Ian Kennedy to produce a review concentrating on improving the understanding the role of culture in the provision of Children's and Young People's Services in the NHS. The report was launched in September 2010. It focuses on those areas where there are cultural barriers to change and improvement. It examines the NHS's position in a wider system of care and support, so as to understand and improve the NHS's provision of services to children and young people. It has already influenced the development of the DoH performance framework.

## **2.10 Sexual Exploitation and Grooming.**

[REDACTED]

The National Working Group for Sexually Exploited Children and Young People (NWG) 2008 describe sexual exploitation as:

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.<sup>17</sup>

There are no national statistics that can be used to identify the scale of the issue but a snapshot is provided by the National Working Group for Sexually Exploited Children and Young People (NWG) and the Child Exploitation and Online Protection Centre (CEOP) who published a report in November 2010 which identified that, of 53 National Working Group services operated by its members in the UK, 2,894 children had been engaged with during the previous year.<sup>18</sup>

Recent child sexual exploitation cases in Derby and Rochdale have raised awareness of the issue of child sexual exploitation. The media reporting of these cases focused on the ethnicity of perpetrators and the children. It's crucial to recognise that just as the ethnicity of the perpetrators differs across the UK, so does that of the children. It is important that we do not allow a stereotype to develop i.e. it is not just Asian men who commit this crime, nor are the victims only white – black and Asian girls are targeted too. It is also important that services do not fail to address issues because of concerns about media or political responses. Statistics and recent media reports suggest that there are concerns nationally regarding some Asian men being involved in the sexual exploitation of young women. This issue can only be addressed by acknowledging it and working with communities and agencies to address it.

The Coalition Government was concerned about the situation and asked the Child Exploitation and Online Protection Centre to undertake a major study into "on-street" grooming and sexual exploitation of children and young people. CEOP should report in July 2011. The study will establish whether it is possible to accurately identify patterns of offending, victimisation or

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<sup>17</sup> DCSF (2009) Safeguarding children and young people from sexual exploitation: supplementary guidance to Working

*Together to Safeguard Children.*

[http://publications.education.gov.uk/eOrderingDownload/Safeguarding\\_CPY\\_from\\_sexual\\_exploitation.pdf](http://publications.education.gov.uk/eOrderingDownload/Safeguarding_CPY_from_sexual_exploitation.pdf), accessed 14 December 2010.

<sup>18</sup> NWG (2010) A national picture of child sexual exploitation and specialist provisions in the UK, [http://www.nationalworkinggroup.org/system/datas/281/original/PDF\\_report\\_2010\\_A4.pdf?1290595299](http://www.nationalworkinggroup.org/system/datas/281/original/PDF_report_2010_A4.pdf?1290595299), accessed 14 December 2010.

vulnerability within grooming and sexual exploitation cases. It will also assess what processes can be put in place to help identify future victims and offenders.

Any child or young person is at risk of sexual exploitation. From any social or ethnic background, boys and young men can be at risk as well as girls and young women. However research<sup>19</sup> has shown that a number of factors can increase a young person's vulnerability to sexual exploitation. These include disrupted and dysfunctional family life and domestic violence, a history of physical or sexual abuse, disadvantage, poor mental health, problematic parenting, parental drug or alcohol misuse and parental mental health problems. Some groups of young people have been identified as being more vulnerable to targeting by the perpetrators. These include looked after children, particularly those in residential care, those who are excluded from mainstream school and those who misuse drugs and alcohol.

Children and young people are systematically groomed by perpetrators. Child sexual exploitation tends to be a hidden activity if services don't develop systems of intelligence and support to identify it. It is much more likely to take place in private residences than visibly, on the streets.

There are a number of indicators that a child is being groomed for sexual exploitation.

These include children:

- going missing for periods of time or regularly returning home late
- being disengaged from education: young people who are not in school during the day may be more at risk of sexual exploitation. Children who are becoming involved in this activity may begin to skip school or become disruptive.
- appearing with unexplained gifts or new possessions
- who associate with other young people involved in exploitation and with older boyfriends/girlfriends.
- who have sexual health issues: a history of unprotected sex leading to sexually transmitted infections or inappropriate sexual behaviour or pregnancy.
- who change in temperament or behaviour?
- who misuse drug and alcohol misuse. Perpetrators may use drugs and alcohol to help control children.
- displaying inappropriate sexualised behaviours.
- involved in exploitative relationships or association with risky adults. Young people may also make reference to risky adults who appear to be connected to each other.

In *Puppet on a String*<sup>20</sup> Barnardo's identify that the following actions would reduce the risk of children and young people being sexually exploited:

- A child centred approach with recognition that children with particular needs or sensitivities are at greater risk and that children and young people do not always identify that they may be being exploited or abused.
- Taking a proactive approach focused on prevention, early identification and intervention as well as disrupting activity and prosecuting perpetrators.

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<sup>19</sup> Scott, S (2001) *Barnardo's PHASE project: a case study evaluation*. University of Liverpool, Liverpool.: Cusick, L (2002) Youth prostitution: a literature review, *Infant Abuse Review* 11: 230-251.

<sup>20</sup> *Puppet on a string: The urgent need to cut children free from sexual exploitation*. Barnardo's, 2011

- Taking account of family history and circumstances in deciding how best to safeguard and promote the welfare of children and young people.
- The rights of children and young people. Children and young people are entitled to be safeguarded from sexual exploitation, just as agencies have duties in respect of safeguarding and promoting their welfare.
- Responsibility for criminal acts. Sexual exploitation of children and young people should not be regarded as criminal behaviour on the part of the child or young person, but as child sexual abuse.
- An integrated approach. *Working Together* sets out a tiered approach to safeguarding: universal, targeted and responsive. Within this, sexual exploitation requires a three-pronged approach tackling prevention, protection and prosecution.
- A shared responsibility. The need for effective joint working between different agencies and professionals underpinned by a strong commitment from managers, a shared understanding of the problem and effective co-ordination by the Local Safeguarding Children Board (LSCB).

In particular, LSCBs should ensure that:

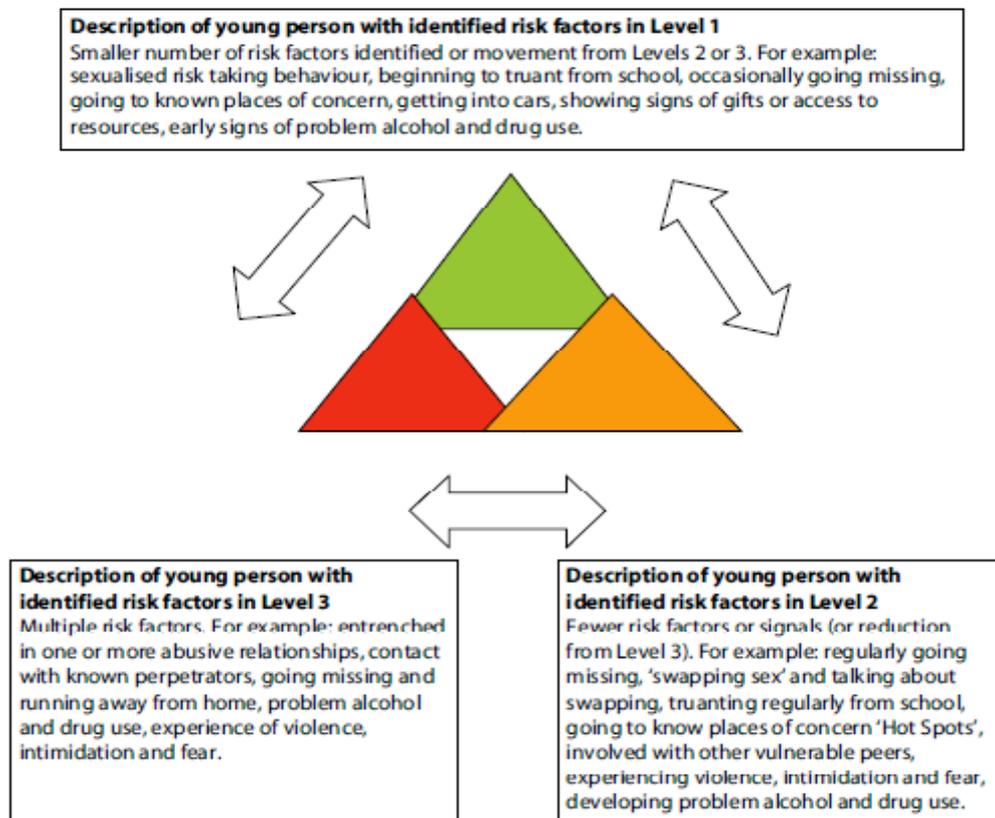
- the needs of children and young people who have been or may be sexually exploited and their families have been considered when planning and commissioning local services;
- specific local procedures are in place covering the sexual exploitation of children and young people;
- local safeguarding training includes information about how to identify the signs of sexual exploitation and an understanding of how to gather evidence which can be used to bring prosecutions against abusers;
- where sexual exploitation is known to be prevalent locally, specialist training is available for key professionals;
- systems are in place to track and monitor cases of sexual exploitation that come to the attention of local agencies;
- a LSCB sub-group is put in place to lead on the issue of sexual exploitation, driving work forward and ensuring effective cooperation between agencies and professionals; there is a dedicated lead person in each partner organisation with responsibility for implementing this guidance;
- arrangements are in place to cooperate with neighbouring areas and those areas where children who have been sexually exploited are believed to have lived or been present.
- their vulnerability is reduced;
- their resilience is improved;
- the activities of perpetrators are disrupted and prevented; and
- tolerance of exploitative behaviour is reduced.<sup>21</sup>

Adapted from the SERA Model developed by The National Working Group for Sexually Exploited Children and Young People, 2008 <sup>22</sup>(from Pearce et al 2002) the diagram below illustrates the types and levels of risk factors which may be identified during an assessment. It also shows how young people can fluctuate between the different levels within the diagram. Their movement from one level to the next is not necessarily progressive: i.e. a

<sup>21</sup> Safeguarding Children and Young People from Sexual Exploitation DCSF 2009

<sup>22</sup> Safeguarding Children and Young People from Sexual Exploitation DCSF 2009

young person deemed to be in Level 1 – the lowest level – may suddenly reveal circumstances and behaviours that might place them within the highest level – 3. However, it is important to recognise that even where the most worrying types of risk factors i.e. Level 3, have been identified, specialist services working with children and young people are able to engage and support them.



In Rotherham in 2009/10 two major police investigations took place into offences of sexual exploitation.

[REDACTED]

[REDACTED] The two investigations were:

- Operation Central

Operation Central was the code\_name given to the investigation and prosecution in Rotherham of a large number of serious sexual offences alleged to have been committed by adult males aged 20\_29 against young girls aged 13\_16. 8 men were charged with a total of 2 offences of rape and 16 of sexual activity with underage girls. Five offenders were found guilty in September 2010. The men received a total of 33 years imprisonment.

- Operation Czar

This operation took place in Rotherham in 2009. It related to sexual exploitation of children and young people in a specific area of Rotherham. The operation did not result in any prosecutions because there was a failure to get victims to disclose offences and therefore to progress complaints.

The RLSCB decided that sexual exploitation would not form part of this review (Lessons to be learned review). Following Operation Central RLSCB commissioned a review which reported in July 2010 to identify the learning that could be taken from the operation. This was not an IMR or an Overview report. As overview author I have looked in detail at the review and have identified from the report the key issues that should form part of this review. The independent author of the report selected to focus on the case of one child to inform the lessons that should be learned. The lessons focus on:

- Improving the performance of strategy meetings and the follow up of agreed actions.
- Ensuring key people attended strategy meetings. The youth offending team (YOT) and Children's Social care were not present at any strategy meeting and made no contribution (despite being actively involved)
- The sharing of crucial information held by the school, children's social care, police and the youth offending team was not submitted to strategy meetings.
- Recognising key indicators – deteriorating school performance, attendance, attainment, attitude, behaviour, changes in demeanour, dress, drugs, alcohol abuse, missing from home, previous offending and youth justice matters etc . These issues were all missed, inadequately represented and inadequately located within the decision making framework.
- Child Sexual Exploitation concerns raised by Project1 and the Police Public Protection Unit were not given adequate priority.
- Information about children missing from education (CME) is properly communicated for safeguarding reasons. Working Together, Chapter 11, is clear that “education is an environment that enables local authorities to safeguard children's welfare; if a child goes missing they could be at risk of significant harm.”
- There was an over reliance upon Safeguarding Unit\_led Strategy Meetings as opposed to effective case management decision making at locality level
- Project1 was found to have developed good working relationships with the police – PPU and Safer Neighbourhood (policing) Teams and this is evident in its intelligence gathering, prosecution support, community prevention strategies and witness support work. The author identifies that there are potential drawbacks in spreading its competence too thinly in order to be the solutions to all things.

The author also spoke to a woman who had been subjected to child sexual exploitation in Rotherham and she felt that to improve services for children and young people that professionals and agencies needed to:

- Improve their knowledge and understanding of Child Sexual exploitation
- Improve training of front line practitioners
- Improve decision making in child protection and risk management and
- Develop specialist services like Project1.

## **2.11 Conclusion Section 2**

The context for the care of Child S and Infant A during 2008 to 2010 identifies that the Children and Young People Services in November 2009 were assessed by Ofsted as not meeting the requirements to safeguard children and young people. The issues raised by Ofsted have been addressed rigorously by Children and Young People Services. Developments in service; planning, governance, addressing workforce issues and the appointment of key individuals should help to address many of the issues raised in the lessons to be learned for Child S at an organisational and

operational level. However many of the developments in this section have still to be implemented or are in the early stages of implementation and therefore there are no outcomes to assess performance. There is a requirement for Children and Young People Services to keep their vision clear and to maintain the determination to achieve the culture and key targets in the Children and Young Peoples Plan. The impact of financial constraints and reconfiguration of services could influence the implementation of the required changes and it is important that the Children and Young Peoples Plan is supported by all partnership organisations to meet the required level and quality of safeguarding services.

## **SECTION THREE - ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS**

The focus for this section of the report will be an analysis of the response of services involved with Child S, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

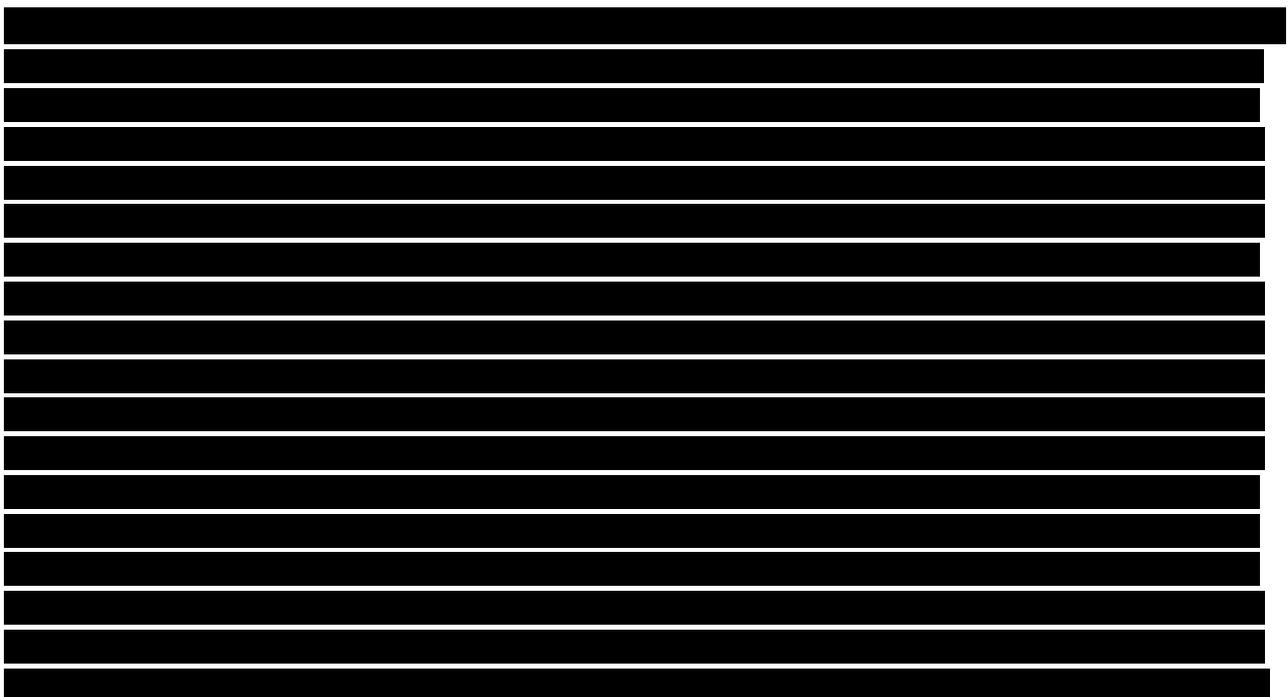
It is important that the findings of the review are set in the context of the internal and external factors that were impacting on delivery of services and professional practice during the period 2002 to 2010. Section Two has been added to provide the reader with an overview of the key issues impacting on the environment of service provision and changes made to address them.

The IMR authors and the overview author have attempted to provide a valid analysis and to cross reference information to complete gaps. Where possible, triangulation of sources of evidence has been used to increase confidence in the findings. All of the agencies involved in this review have provided frank accounts of their involvement in order to learn lessons to reduce the risk of this happening to children in the future.

The format of the analysis sections varies to reflect the requirements of each agency. In order to manage an account of agencies' involvement with Child S and Infant A the author has described separate involvement of each agency.

### **3.1 Rotherham Metropolitan Borough Council - Children's Social Care Services (CSCS) and Youth Offending Service**

The IMR author divides the summary and analysis of Children's Social Care Services (CSCS) into two timescales 2002 to 2008 and 2008 to 2010. The Youth Offending Services are summarised and analysed in the first timescale.



[REDACTED]

[REDACTED]

**Analysis of Rotherham Borough Council – Children’s Social Care Services**

[REDACTED]

[REDACTED] In 2005 Child S was removed from the Child Protection Register at the first review conference although an assessment had not been completed and there was evidence that her behaviour and the risk to her from the activities in the family. Although Child S was de-registered she remained as a Child in Need for a further 2 and half years. The IMR author’s impression from the records is that Child S never co-operated with CSCS and was never effectively assessed.

During 2007 CSCS’s role was largely restricted to co-coordinating Children in Need meetings and making a referral to Project1. Social Care was trying to cease their involvement with Child S during this period. Although neither Project1 and/or the NHS Learning Disability Specialist Team were not involved with Child S CSCS’s involvement ceased in September 2007. Meanwhile Child S’s behaviour at home and school continued to be a source of concern with indications that she was becoming sexually active and potentially putting herself at risk of sexual exploitation from older males. By the time CSCS ceased their involvement there were indications that Child S might be getting herself into risky situations

[REDACTED]. Despite this CSCS ceased their involvement before other specialist services were able to become involved.

There is evidence that on three occasions during this period SW2 undertook to make enquiries in respect of inappropriate behaviour in which Child S had allegedly been engaged but there is no evidence that these enquiries were ever made. In addition, although Child S remained a Child in Need throughout this period Children in Need meetings were only held sporadically.

### **Youth Offending Team**

The Youth Offending Team was involved with Child S from July 2007 to September 2007 following an incident of assault on a girl at school in July 2007 when Child S was 13 years old. Child S was excluded from school and was given a final warning by the Police. Child S refused to undertake Victim Awareness work. Adult B was contacted regarding Child S having a mental health assessment but no further action was taken because Child S had been referred for an assessment to the NHS Learning Disability Specialist Support Team. SW2 in CSCS was contacted by the police and informed that Child S had received the final warning. A drug and alcohol awareness session was undertaken with Child S and Adult B.

### **Analysis of Rotherham Borough Council - Youth Offending Service**

The case was closed even though Child S had not complied with the Victim Awareness intervention and therefore she had technically not complied with the order. This decision said to have been made as a result of Child S being 13 years old and having learning difficulties. There is no indication of any contact with CSCS or of obtaining expert advice about working with a child with learning difficulties. This is the only involvement that the Youth Offending Team ever had with Child S.

### **Summary of involvement of CSCS from September 2008 – October 2010**

During 1 September 2008 – 31 August 2009, CSCS had no direct contact with Child S. There are four entries in her records for this period two of which concern Sibling 3 rather than Child S. One of these related to a letter to Adult B to advise her that the 14+ opinion was that Child S did not meet the criteria of a disabled child in the 1989 Children Act.

[REDACTED]

In September 2009 Project1 informed CSCS that Child S was believed to be at risk of sexual exploitation due to associating with men who were named on a referral regarding another girl Child Y. The address given for Child S on this contact was an address within the geographical area covered by the team managed by TM2, who was on leave that week. TM1 screened the referral and decided that a duty worker should undertake a home visit in order to discuss the nature of the referral with the parents of Child S and to advise that it is the parents' responsibility to ensure Child S's safety. Two days later, before any visit had taken place, SW4 completed documentation



was in addition to her usual job as locality manager, in which she managed the team managers for the three teams which comprised South Locality.

At the time Operation Czar commenced Rotherham Children's Services was under notice to improve having been judged by Ofsted to be performing poorly in the children's services annual rating in December 2009. In addition there were significant problems recruiting suitable staff which resulted in there being several vacant posts within locality teams and a number of social work and team manager posts which were occupied by short-term agency staff. Although funding was agreed for two additional social work posts SM1 was unable to recruit so the plan changed and a team was established which comprised one qualified social worker and two family support workers. In the minutes of the meeting, held on 1 February 2010 it was recorded that two family support workers had already commenced work and a social worker would start on 9 February 2010. The team comprised one qualified social worker and two people who were working as family support workers but training to become social workers. This included FSW1 who at the time she worked as a family support worker with Child S, had undertaken sufficient work to have been awarded a Post-Graduate Diploma in Social Work but was progressing her studies to a higher level. These three staff normally worked in South Locality but for the purpose of Operation Czar they also worked with young people who lived in other areas of Rotherham.

At the strategy meeting on 20 January 2010, SM1 agreed to ensure that risk assessments in respect of all the young people would commence that day. She acknowledged that it was agreed at the meeting that she would commence background checks on all the girls but the staff were not in place at that time so it was not possible to commence assessments immediately. Further strategy meetings were held in February 2010 at which it was noted that Child S was pregnant. In March 2010, SM1 requested that an initial assessment be undertaken with Child S. Child S was not identified as being one of the girls who was most at risk of sexual exploitation and therefore other girls had been identified as higher priority for assessment and intervention. Child S was allocated to FSW1 who remained Child S's allocated key worker from 1 March 2010 to 27 August 2010.

Whilst SM1 directly line managed the staff working in the sexual exploitation investigation they had supervision with their usual team managers. At that time there were two team managers covering three posts in the locality. Team managers were asked to keep in touch with the cases in their supervision with the staff. FSW1 and TM3 both acknowledged that during supervision they did discuss the sexual exploitation cases but TM3 said that these discussions were "brief and vague". The Team Managers were expected to carry out some of the practical tasks associated with administration, endorsing Initial Assessments and closing cases.

SM1 did not provide planned individual supervision to the staff involved in the sexual exploitation investigation. There were two occasions when three staff involved in the sexual exploitation team had group supervision and update on progress and to discuss what needed to happen next. There was not always a written record made of SM1's discussions with these staff. With specific regard to Child S the case record contains one supervision note which was written in June 2010 by TM3, FSW1's Team Manager. There is also a note written by SM1 in August 2010 regarding the decision to close Child S's case. There are no other records of supervision or any management decisions.

FSW1 and FSW2 commenced a joint initial assessment with Child S on 4 March 2010. The assessment identified that:

- Adult B did not feel that Child S was at risk of sexual exploitation and said she did not go out very often,
- Child S acknowledge that she went to the home of one older male (the one where the incident with the firearm occurred) where she and her friends “hang out, smoke and drink alcohol”. She referred to this man as a “pervert”.
- Child S would not disclose the identity of Infant A’s father to FSW1 but both Child S and Adult B said that she was no longer in a relationship with him.

[REDACTED]

[REDACTED] Adult B also said that she will support Child S with the baby.

The summary of the initial assessment identified work to take place with Child S to improve her understanding of the grooming process, a pre-birth assessment in relation to the unborn child and work with Adult B around her understanding of sexual exploitation, and how she could parent and protect Child S more effectively.

The assessment of work required with Child S and Adult B was not translated into an initial plan. There is no written pre-birth assessment on the case records. There is a difference of opinion about the expectations of work with Child S at that time. FSW1 explained that a pre-birth assessment was not written but SM1 asked her to check that Child S was emotionally ready for the baby, had support in place and had appropriate equipment. She added that she was not asked to undertake a core assessment. SM1 said that she anticipated that there would have been a full pre-birth assessment on the core assessment documentation. The Team Manager would usually start this on SWIFT and it would have to have been carried out by a qualified Social Worker. SM1 believed that this would be done by a social worker in the Locality Team as it concerned Child S’s unborn baby and was not part of the sexual exploitation investigation.

Following completion of the initial assessment on 8 March 2010 until the time of Infant A’s birth on 23 June 2010 FSW1 carried out three pre-arranged visits to Child S’s home. Two visits FSW1 met Adult B only and completed the initial assessment with her. The third visit from FSW1 was on 11 May 2010 when she met with Child S and Adult B. Therefore this was the only occasion when FSW1 saw Child S between the completion of the initial assessment and the birth of Infant A. FSW1 has recorded that at this visit they spoke about grooming and exploitation and Child S did not seem to understand that the girls involved were victims.

There is only one record of any communication between CSCS and any other agency concerning Child S during this period March 2010 and the birth of Infant A. This is the enquiry from the teenage pregnancy midwife on 19 May 2010 passing on concerns reportedly held Project1 about whether Child S had the intelligence to care for a baby but FSW1 and other professionals did not share these concerns.

On 23 June 2010 Child S gave birth to Infant A. The following day hospital midwife and Adult B both spoke to FSW1. Hospital midwife wanted information about Child S and also wanted to keep her in hospital for a few days but acknowledged that she did not have any grounds to do so. Child S and Adult B both wanted Child S and Infant A to be discharged. FSW1 stated clearly to the hospital midwife and to Adult B that she had “no concerns” regarding Child S or Infant A. At

interview SM1 stated that she was told that hospital staff had no concerns about Child S when the baby was born. If she had known about the enquiry from the hospital midwife she would have wanted to know more about the concerns they had. FSW1 carried out a home visit on 25 June 2010. The case record suggests that discussion at this visit focused on how well the first night at home had gone and the care of Infant A.

FSW1 next carried out a home visit five weeks later, on 27 July 2010, in response to a phone call from Health Visitor 2, earlier the same day. HV2 expressed three concerns about the family. Firstly that she had not seen Child S handle Infant A and she believed that Adult B was doing the majority of the caring tasks,

[REDACTED]

At the visit on 27 July 2010 FSW1 saw Adult B and Infant A but did not see Child S who was said to be in bed asleep having been up all night.

[REDACTED]

FSW1 did not agree with HV2's concern that Child S was leaving Adult B to care for Infant A. Her view was that Child S was willing to care for Infant A but Adult B often undertook caring tasks because she was "there on the spot". This belief was based on the fact that Adult B had always been clear that she was not prepared to take on the majority of the caring for the baby and when FSW1 visited, Adult B said that Child S was doing most of the caring. SM1 was aware that HV2 had expressed concern that she had not seen Child S handling Infant A. Her understanding was that FSW1 and HV2 had undertaken a joint visit.

On 5 August 2010, FSW1 and SM1 had a discussion and SM1 decided that Child S's case should be closed. SM1 recorded that this was because all the work recommended on the initial assessment had been completed and there had been no further concerns relating to sexual exploitation. It was agreed that FSW1 would visit Child S and Adult B to inform them and that HV2 would be contacted to inform her that the case was being closed and that she should contact CSCS if there were any concerns. Following this FSW1 was to complete a closing summary.

FSW1 undertook a home visit on 10 August 2010 where she found that Infant A was being cared for by Adult B and Child S's aunt. Adult B explained that Child S had gone out with her cousin but that she cared for Infant A most of the time. FSW1 carried out a further home visit on 26 August 2010 when she did manage to see Child S who said that everything was going well and also that she had stopped associating with her friend since one of her children had hit Infant A. This was the first time that anyone from CSCS had seen Child S since FSW1's visit on 25 June 2010.

On 27 August 2010, the day after her visit to Child S, FSW1 tried to contact HV2. SFN1 returned the call on HV2's behalf and was told that Child S's case was going to be closed and that HV2 should re-refer if she had any concerns regarding Infant A. The same day, FSW1 wrote a case closure summary and ceased her involvement with the family.

FSW1 saw Child S on five occasions; twice in March 2010 when she undertook the initial assessment, once more before the birth of Infant A, once the day after Infant A was brought home from hospital and on 26 August 2010 when she was closing the case.

FSW1 confirmed at interview that she never found out the identity of Infant A's father and therefore he was not assessed in any way. She explained that Child S was clear that the father had said he did not want to be involved with Infant A. There are a number of issues known to CSCS associated with the father of Infant A which include:

- [REDACTED] At the time of the Initial Assessment Child S refused to divulge the identity of Infant A's father but said they had split up.
- In June 2010 Child S and Adult B stated that he had not been in touch and they had not contacted him.  
[REDACTED]
- In July 2010 Adult B told her that Child S had seen a member of Infant A's father's family in the street and they had denied that Infant A was part of their family.  
[REDACTED]
- Adult B also told FSW1 that Child S was now considering going to the Child Support Agency to claim money for Infant A.
- Examination of Child S's records by the IMR author has identified that they include a name for Infant A's father, something the family had previously refused to provide.

SM1 stated at interview that FSW1 told her, on a number of occasions that Child S would not divulge the identity of Infant A's father and that the police and Project1 said that Child S would not give them this information either. SM1 also stated that she was not aware of the incident when Child S had seen a member of the father's family and, if she had been aware, she would have wanted to know who he was so that any risks could be assessed. SM1 felt that this incident demonstrated that there was the potential for interaction between Child S and Infant A's father.

On Saturday 18 September 2010, three weeks after FSW1 had closed Child S's case the police notified Social Care that Child S had left her mother's home and taken Infant A to stay with her at a friend's house.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Subsequently the designated safeguarding manager from College1 contacted CSCS expressing similar concerns about Child S and Infant A

having left Adult B's home and specifically stating that he had safeguarding concerns about both Child S and Infant A.

TM4 explained at interview that following receipt of the contact concerning Child S and Infant A she checked the records and, because Child S had been open to a worker from South Locality within the past three months she contacted the Access Team and asked for it to be sent back to South Locality in line with agreed procedure. She was then contacted by SM1 who said that South Locality would not pick up the case because the previous involvement had been as part of Operation Czar. TM4 was aware of Operation Czar but said, at interview, that it was not evident from Child S's case record that this was a case that involved concerns about sexual exploitation. The records did not contain any strategy meeting minutes and although there were references to an initial assessment and a pre-birth assessment neither of these documents were in the records and there was nothing in the records to give cause for concern. SM1 informed TM4 that if there were concerns about Infant A then these needed to be allocated to the North Team. SM1 also wrote that she was happy for FSW1 to undertake an initial joint visit with the worker from North Team. TM4 did not take up this offer of a joint visit involving FSW1 and that there was no discussion at all with FSW1.

Four days later TM4 allocated Infant A to SW7.

[REDACTED]  
[REDACTED] After discussion with Child S and Adult B, Child S returned to Adult B's care that same day, taking Infant A with her. SW7 visited to carry out an Initial Assessment of Infant A. The outcome of the Initial Assessment was that Child S handled Infant A appropriately but there were concerns about her leaving Infant A in the care of other adults. Adult B was assessed to be a huge source of support which was considered to be a protective factor and an agreement was written to the effect that Infant A would be left in Adult B's care whenever Child S went out. Two days later SW7 visited Adult B and Child S again and a Contract of Expectations was agreed and signed. SW7 then went on annual leave and had no further involvement with the family prior to Child S's death.

SW7 did not have contact with either of the referring agencies prior to or following the visit to Child S and Infant A although she was aware that the duty worker had made contact with agencies. SW7 did not consult with HV2 at the time of the assessment as the case had only been closed by CSCS three weeks before and the concerns that had led to this referral were not about the health needs of Infant A. SW7 was allocated Infant A, not Child S, and she understood that someone else, from a different team was going to visit to assess Child S. Nevertheless, as part of Infant A's initial assessment she had a long discussion with Child S about sexual exploitation. She felt that she had to phrase things carefully because of Child S's learning difficulties and she tried to ensure that Child S had understood her.

On [REDACTED] FSW1 raised a contact concerning Child S. FSW1 was on annual leave but saw on Facebook that someone in Rotherham, with Child S's name was missing and she was concerned that it may be Child S. TM4 made enquiries which revealed that Child S was missing, that a body had been found, but not yet identified and that Infant A was being cared for by Adult B.

On 13 October 2010 TM4 was informed the Police Family Liaison Officer that he was seeing Adult B and Infant A everyday and that Infant A appeared to be well cared for. He advised that it would

not be appropriate for Social Care to make contact with Adult B at the present time. TM4 explained at interview that she did have some concerns about not seeing Infant A because she was being cared for by someone who did not have parental responsibility for her. She added that she cannot remember when CSCS was able to see Infant A.

## **Analysis of Rotherham Borough Council – Children’s Social Care Services**

Following the end of CSCS involvement with Child S in September 2007, there was no direct contact with her until two and a half years later in March 2010. The IMR author identifies that the records suggest that it would have been appropriate to have involvement with her in September 2009 but nothing in the records suggests that any information was brought to the attention of CSCS between September 2007 and September 2009 that might have warranted intervention. By the time CSCS became involved again Child S was pregnant, aged 16 years of age, and was not in a relationship with the father.

In September 2009 an opportunity to assess Child S was missed, apparently as a result of confusion regarding her address. This highlights the difficulty in keeping information accurate and current and also problems that can arise when records are changed based on unverified information. The referral was from Project1 and whilst it did not provide specific information regarding risks to Child S, but general concern, a review of her case records would have quickly identified that there had been previous concerns regarding sexual exploitation, which in turn should have increased concerns about her and led to greater attempts to locate her. However this did not happen because of the incorrect change of address. No further action was taken to locate Child S or to undertake an assessment. At the very least, contact should have been made with Child S’s school to identify where she was living. Similarly, had it been identified that the change of address had only just been entered onto SWIFT database it would have been appropriate to have followed up where this information had come from.

[REDACTED]

[REDACTED] It is now clear that a strategy meeting had already been held due to similar concerns regarding this group of girls (Operation Czar) and that a series of strategy meetings followed in September 2009. CSCS were invited but not involved in the strategy meeting and YOS was not invited. However, for some reason, although Child S was named at the first meeting, her needs were not considered until four months later in January 2010.

The IMR Author notes that at the strategy meeting 18 young people who were named as subjects of the strategy meeting were discussed but not in significant detail. This raises the question of how practical it is for one meeting to address the needs of such a large number of young people.

When Child S was discussed, in January 2010, it was decided that she should be assessed but there was a further delay of six weeks before this assessment commenced. In part it appears that this delay was due to the difficulty Social Care experienced identifying staff to work on the sexual exploitation team and back filling their substantive posts. This difficulty was symptomatic of a wider problem the service was facing with recruiting to social work posts but there were staff in post much earlier who could have undertaken the assessment. SM1 has stated that Child S was not identified as one of the girls who were highest priority for assessment and intervention. The

lack of information about Child S in the minutes from the strategy meeting on 20 January 2010 makes it difficult to judge whether this was the correct decision and suggests that she was identified as a lower priority because so little was known about her. When engagement did take place it involved a member of staff who was not suitably qualified and who received insufficient support and supervision. An unqualified and relatively inexperienced family support worker was allocated to work with Child S. The work that was identified as needing to be done was never completed.

The initial assessment identified three areas of work that needed to be undertaken with Child S and/or her mother. Two of these related to the concerns about sexual exploitation and the other concerned the fact that Child S was pregnant and that a pre-birth assessment should be undertaken. All three seem to have been appropriate areas to address. However, there is no written work plan and it appears that there was never a clear, agreed plan identifying how this work would be carried out or what would represent an acceptable outcome. What is evident from the CSCS IMR is that the social work input that Child S received was case management rather than the social worker undertaking direct one to one work.

What is clear from the CSCS IMR is that FSW1, who was directly working with Child S and SM1 her manager had a different understanding to one another of what work was going to be undertaken in relation to sexual exploitation and grooming and pre-birth assessment in January 2010. SM1 expected a formal, planned piece of work using tools provided by Project1 whereas the actual work was limited to one discussion which, it was recognised at the time, Child S had struggled to understand. It is hard to see how it could possibly be considered that the planned work had been completed.

It is less clear what work was expected to be undertaken with Adult B but records suggest that little was done beyond one discussion regarding sexual exploitation. Adult B did not accept that Child S was at risk of sexual exploitation and consistently reported that Child S was no longer going out very often. FSW1 believed that Adult B was supportive of the work being done and was very knowledgeable about sexual exploitation, indeed she commented at interview that Adult B probably knew more about it than she herself did. It seems likely that FSW1 found it difficult to challenge Adult B even though FSW1 was aware that Adult B did not always give her full information about things. It is not clear if what FSW1 addressed this with Adult B.

The IMR author identifies that interviews conducted for the IMR revealed again a marked difference of view between FSW1 and SM1 regarding what was required for the pre-birth assessment. This difference of understanding suggests that there was a lack of clear management direction following the initial assessment and the fact that SM1 did not discover until sometime later that there had not been a formal written pre-birth assessment suggests that supervision was inadequate. The initial referral was due to the sexual exploitation investigation and not because of Child S's pregnancy but the risk factors were such that, having become involved with Child S whilst she was pregnant, it was incumbent on CSCS to fully assess her ability to care for her baby. These risk factors included the following:

- Child S was 16 years old and reportedly no longer in a relationship with the baby's father  
[REDACTED]
- Adult B had had difficulties parenting her children.
- Child S had a learning difficulty which had resulted in her attending a special school.

Not only did no formal written assessment take place but records suggest that the work done with Child S in preparation for the birth of her baby was not even as thorough as FSW1 suggests. Child S was not present at the visit that FSW1 arranged to go through the pre-birth assessment and the only references in the case record that could be construed as relating to Child S's readiness to become a mother are that Adult B showed FSW1 various items of equipment; that Adult B said she had told Child S that she (Adult B) was there to support but not to look after the baby all the time and that Child S had refused to go to the Centre1 for parenting classes. FSW1 did not initiate contact with any other agencies about Child S's readiness to care for a baby and when the teenage pregnancy midwife told her that Project1 had concerns she dismissed these concerns without any follow up or discussion with her manager.

The decision to close Child S's case, in August 2010, was based on the belief that all work recommended in the initial assessment had been completed and there had been no further concerns reported in relation to sexual exploitation. It is correct the IMR author states that there had been no further concerns reported in relation to sexual exploitation but none of the work recommended in the initial assessment had been successfully completed and the concern expressed by HV2 about Child S and Infant A had not been satisfactorily addressed

CSCS' ongoing involvement provided an opportunity to assess how Child S coped with being a mother following the birth of Infant A. In the event no such assessment was made and when concerns were raised by HV2 the response was inadequate. FSW1's rebuttal of HV2's concern that Child S was not providing the necessary care to Infant A but was relying on Adult B was based on one home visit which had been made the day after Child S had brought Infant A home from hospital. FSW1's subsequent visits should have given credence to HV2's concerns as Adult B was caring for Infant A on both occasions. Instead FSW1 accepted Adult B's assertion that Child S usually cared for Infant A. FSW1's assertion that Child S deliberately absented herself from these visits because she did not want to see FSW1 is not supported by the evidence as one of the visits is recorded as having been an unannounced visit.

There was also no joint working with the health visitor but instead, a month after she had raised her concerns, a message was left for the health visitor to tell her that the case was being closed and she should re-refer if her concerns persisted. There was no consideration of Child S's learning difficulties and the possible impact on her being able to parent effectively.

It is therefore clear that the decision to close Child S's case was based on an incorrect understanding of the situation and consequently the author of the IMR considers that the case should not have been closed at that time. This incorrect understanding of the situation reinforces the view that the unqualified and relatively inexperienced family support worker working this case did not receive sufficient supervision.

The IMR author indicates that CSCS were presented with a refusal from Child S and Adult B to disclose the identity of Infant A's father and a consistent statement that he was no longer in a relationship with Child S and did not want anything to do with Infant A. However, Child S' case records include a name for Infant A's father, something the family had previously refused to provide. The assessment also states that Infant A's father's family "are not aware of Infant A's existence" a statement which was totally inconsistent with information provided previously. Had these inconsistencies been identified it may have been possible to have found out more about

Infant A's father which may, in turn, have allowed a better assessment to be made of any potential risk to Child S and Infant A.

Adult B also stated that the Police had called round looking for Infant A's father suggests that the Police were aware of his identity and it would have been prudent to have had a discussion with the Police at that stage to enable a risk assessment to have been completed. The fact that Child S shaved Infant A's head and talked about bringing her up as a Muslim appears to be at odds with the assertion that she did not want anything to do with Infant A's father's family. Similarly the report of Adult B going to Infant A's father's family's home and berating them should have been a cause for concern as it demonstrated the potential for antagonism between the two families. The suggestion that Child S might pursue financial support through the Child Support Agency demonstrated the potential for ongoing contact between them. There was no assessment of the potential risk to Child S or Infant A and the concern that Child S was involved in sexual exploitation.

Throughout this period of involvement Adult B was seen as a reliable, supportive adult who was a protective influence on Child S. This can be seen by the fact that she was taken at her word when she said that Child S was no longer having much contact with her previous friends and acquaintances and also when she said that Child S was undertaking the majority of the caring tasks for Infant A. However at interview FSW1 acknowledged that Adult B did not always give her full information about Child S's behaviour.

FSW1 described Adult B as being very knowledgeable about sexual exploitation and suggested that she could help to raise Child S's awareness of this.

[REDACTED]  
[REDACTED]  
[REDACTED] It also appears to contradict one outcome of the initial assessment which was to work with Adult B around her understanding of sexual exploitation. The author of the IMR considers that too much reliance was placed on Adult B both to protect Child S and to provide an accurate picture of her behaviour. In addition it may be that FSW1 was uncomfortable challenging Adult B given her perceived knowledge and experience. This was not an easy situation for an inexperienced and unqualified worker.

The arrangements for supervision and management of Operation Czar and potential sexual exploitation cases were unclear with the potential for miscommunication and misunderstandings. SM1 was given the responsibility for establishing the team but her role in the ongoing operation of the team was not clearly defined. As a service manager she would not usually have provided line management and supervision to front line social work staff. It appears that in the absence of any specific team management time for the sexual exploitation team, SM1 took on the role of line manager but did not fulfil all aspects of the role. In the case of Child S this resulted, on a number of occasions, in a lack of direction or misunderstandings about what action should be taken. For example, SM1 intended that a pre-birth assessment would be carried out and remained unaware for a period of time that this had not been done and the initial plan section of the assessment was never written. In addition SM1 was unaware of a number of potentially significant incidents which, she says, would have affected her decision making about the case. These include the apparent concerns expressed by Project1 about Child S's ability to care for a baby, the fact that FSW1 did not see Child S caring for Infant A during the two visits she carried out after the HV2 had

expressed concerns about this, and the contact that took place between Child S, Adult B and Infant A's father's family in July 2010.

It is unclear what role the Team Managers were expected to undertake in respect of supervising these cases and this must have been a source of some confusion for them and for the front line staff. There were positive, sensible reasons for co-ordinating all the sexual exploitation cases to avoid the difficulties with fragmentation that had been experienced with Operation Central. However, certainly in respect of Child S, this approach was undermined because there was not one manager providing the full range of Team Manager duties to the FSW1.

Coupled with the lack of management was the fact that, contrary to regulations, the initial assessment of Child S was carried out by a family support worker not a qualified social worker. Information gathered during the course of this review suggests that practice in Rotherham has been inconsistent with some, but not all, teams using family support workers to undertake initial assessments. However, it is reported that this practice has now been stopped and all initial assessments are now led by a qualified social worker.

It is accepted that there were difficulties releasing sufficient qualified social workers to work on the sexual exploitation investigation and that the family support workers were training as social workers and were believed to have relevant skills, experience and potential. It is also accepted that SM1 intended that the qualified social worker working as part of Operation Czar would undertake joint visits with the family support workers in order to undertake initial assessments and that this would have been consistent with FSW1's previous level of working. However, this did not happen in the case of Child S. The reason for this is unknown. It would have been challenging for an experienced social worker to work with the complexity of working with Child S.

On 20<sup>th</sup> September 2010 a referral was received from College1 and the police regarding Child S and Infant A with concerns that as Child S had left home both of them were at risk. Following the referrals from the police and the college there was a delay of two days before anyone from CSCS made contact with Child S or Adult B. There was some confusion about which team should pick up the referral. The immediate problem was resolved with Child S and Infant A returning to live with Adult B. This delay given the history of the Child S and the risk to Infant A was not acceptable. The initial assessment is thorough although it appears that the information came entirely from Child S and her mother, coupled with the Social Workers own observations, when there should have been some communication with the health visitor or GP, in her absence, someone else from that team to verify information and clarify their view of the situation.

Information provided by the police in their referral suggested that Child S was maintaining some potentially unsuitable relationships and during the assessment Adult B complained that Child S was going out too much. This was different from the picture that Adult B had presented a few weeks previously when FSW1 had ceased her involvement. To someone who knew the case this could have led to concern that Child S was still at risk of sexual exploitation and should, at the very least, have resulted in a further assessment of Child S.

SW7 did discuss issues of sexual exploitation with Child S but the focus of her work was on Infant A and the completion of a Contract of Expectations which is a form developed by RMBC. SW7 completed with Child S and Adult B a Contract of Expectations to try to prevent Child S from putting Infant A in risky situation again. However, the contract dealt entirely with keeping Infant A

safe and did not pay any attention to ensuring that Child S herself took responsibility for caring for her child. Neither did it address Child S's safety. This focus was too narrow given that the original referral identified safeguarding concerns for both Child S and Infant A and the initial assessment identified that Adult B was unhappy that Child S was not taking greater responsibility for Infant A. There was no indication of the likely consequences if the family failed to comply with the Contract of Expectations with the result that it had little or no authority. No arrangements were made to monitor compliance with Contract of Expectations that was agreed in September 2010 and there was no reference to the likely consequence of any failure to comply with it. As such the Contract of Expectations had no authority attached to it. It almost gives professionals a false sense of security. Little attention was paid to Child S's Learning Disability and no expert advice was sought about this. When it was felt that she was having difficulty understanding issues regarding sexual exploitation this matter was not pursued. It would have been more appropriate to have sought advice as to how to help her to understand

SW7 believed this work was going to be done by someone else but this did not happen and no-one else who has been interviewed for the IMR shared SW7's belief. The author of the IMR considers that it would not have been good practice to have allocated Infant A to a worker from one team and Child S to one from another team as this would have been a very fragmented service with the potential for significant assessment and practice difficulties

In [REDACTED] Child S had been missing for three days before CSCS became aware of this. It is a matter of surprise that the Police had not made CSCS aware of Child S's absence given her previous involvement in the sexual exploitation investigation, that she herself was a minor and that she had a baby. During the three days from [REDACTED] CSCS acted appropriately in quickly confirming Infant A's whereabouts and seeking information about her wellbeing. Whilst the IMR author states that given the circumstances it was probably correct not to visit the home at that time CSCS had a responsibility for the safety of Infant A and a visit at this time with police discussion would have enabled an assessment to be made of the best care environment for Infant A.

Whilst the focus of the IMR author's comments in line with the recommendations relates to the time period of 2008 to 2010, the first period of contact with Child S from 2004 to 2008 is crucial to understanding the pattern of relationships and style of services developed with Child S and her family in the future in relation to:

- Professionals failed to listen and consider situations from Child S's perspective. She was invisible.
- Child Protection Conferences and Children in Need meetings were inadequately managed and evaluated in that there was a lack of constant reappraisal of the information available. The history of the Child S and her family was available to most of the agencies and individual practitioners if they had taken the time to make a fully informed assessment and therefore develop a case management plan. Sharing information that did not translate into the required level of shared analysis, planning and interagency practice.
- As the situation deteriorated the level of vulnerability of Child S was not systematically evaluated and therefore the skills, knowledge and support of additional services were never effectively requested or addressed



### **3.2 Rotherham Metropolitan Borough Council - Education Services**

The author of the IMR has divided the IMR into two timescales;

- From 2002 to 2008 which correctly sets the context for an in depth review of Child S's educational experience by referring back to 2002 and mapping out Child S's development and educational experience.
- The author then utilises this information to examine the period September 2008 until [REDACTED] the date when Child S' was confirmed dead.

#### **Period 2002 to 2008**

During this period Child S firstly attended School2 and then moved to a School1 (special school) in 2004. The IMR author provides an understanding of the assessment and evaluation of progress of Child S educational needs that took place from 2002 to 2008.

Child S's Amended Final Statement of Special Educational Needs in 2002 increased teaching assistant support for Child S. This additional support does not appear to have impacted greatly on Child S as the review in 2003/2004 identified that she had only achieved 20% of set targets. There is no indication in the IMR if there was evidence of a structured approach to school assessment in between the annual reviews. However Ofsted review of the School 2 in 2001 states that:

*'The procedures for monitoring and supporting academic and personal progress are very good and the procedures for monitoring and supporting pupils' personal development are good'.*

In 2003 /2004 School2 were said to be working with Child S to prepare her for transition to the local comprehensive school. A letter was sent to Adult B informing her of this. A further review of Child S's special educational needs was undertaken which this time involved the Educational Psychology Service. Child S was 10 years 8 months at this time. She was assessed as having an IQ of 56 , a basic reading and spelling age of 6, she could not write a simple sentence independently and her numeracy was at year 2 (instead of year 5). This required a new statement in July 2004 which resulted in Child S attending a special school in September 2004.

In Child S's 2003/4 Annual review it is identified a pattern of attendance where she was absent from school for one day per week for most weeks and was sometimes late. Her attitude was said to be good although she could refuse to do work.

In November 2004 Child S was placed on Child Protection Register

[REDACTED] School1 were aware of this although they did not attend the Child Protection Conference although invited. In 2005 this was reviewed and Child S was removed from the register but was identified as a Child in Need until 2007.

The first annual review conducted by School1 in 2005 indicated that Child S's attendance was good but there were some difficulties getting her into the classroom. It describes Child S as a child who lacked confidence and whose behaviour was unpredictable. She was said to be making progress but only two of the educational five targets set as part of her 2004 annual review were achieved.

Child S's behaviour was obviously severe enough to cause concern as Child S was referred to Centre2 which provides Tier 3 specialist Child and Adolescent Mental Health Services (CAMHS) services in Rotherham. The service is an outpatient service with a multi-disciplinary team offering tier three services for a range of emotional and psychological problems. These include psychiatry services, family therapy, group therapies and a range of individual work

In September 2005 the family moved house but Child S continued to attend the School1. In November 2005 there appears to have been a significant change in the behaviour of Child S. She refused to go into lessons, was disruptive and wearing inappropriate clothing rather than school uniform. Her general behaviour was said to be a cause for concern.

Child S's annual review 2005-2006 (age 12 years) identified that she had achieved one target out of the five set. There were problems at home which were said to be significantly impacting on Child S. She moved to a new class. Whilst she was attending she was difficult to get into lessons, left without permission and was unsettled and moody and used bad language. She was finding difficulty interacting with other pupils and rude to staff. This was said to be impacting on her educational progress. Adult B was not at the review. It was decided to involve the pupil support team to help her to work on her behaviour. This assessment provides a clear picture of the issues.

It was not until 2007 that the Education Welfare Service was asked to become involved with Child S. SEWO1 wrote to Adult B about Child S' attendance which at this stage was 61%. There is no record on the school file that this took place and the education welfare service has no record of being contacted.

In 2007 Child S was still identified as a Child in Need. She was absent for most of the spring term. When she attended she did not work. She was violent needed restraining on occasions and targeted other pupils and was said to be cruel to them. The school provided classroom support and mentoring. Staff reported to the IMR author that they were at a loss of what they could do to help Child S.

In April 2007 Child S aged 14 years was receiving help from the Pupil Support Team and a learning mentor with a behaviour management programme for two sessions per week. She also was referred to Listen Up, Centre4 and Project2 but did not attend as she said she thought they were boring.

ListenUp programme designed to save teachers time while improving social, emotional, and academic performance in the school setting. It has also been designed to strengthen relationships between students, their families, and teachers.

Project2 Learning Centre providing facilities for young people who are looking for an alternative curriculum. Here, young people can learn how to learn again, reach their own potential, achieve qualifications and take exams, receive pastoral support and work towards their own goals. When the time comes for them to leave school, they can move on to the Stepping Stone project where they will be supported until they find work, move on to further education or join the NEETs programme and

Centre4 which is a community based Arts, Education and Activity Centre.

In July 2007 Child S was referred to Project1. Project1 works with young women at risk of sexual exploitation. It is based within Rotherham Young People's Services. Workers can work in schools with young women about sexual exploitation and 'grooming'. They also do work on on-line protection and are trained CEOP (Child Exploitation and Online Protection) ambassadors. Unfortunately Project1 was not accepting referrals at this time.

The December 2007 annual review of Child S' progress was not attended by either Adult B or Child S. Her attendance rate was 66% at this stage. She maintained a negative attitude to the school and was still disruptive and aggressive. Child S had stated attending a hair and beauty course at College1 as part of an alternative curriculum. Child S was enthusiastic about this but by January 2008 Child S was not attending College1 or the School.

### **Period 2008 to 2010**

This period covers Child S's final years at school 2008/09 and first year at College1. During this period the IMR author identified that a modified learning package was developed to meet the long term needs of Child S. A contract was agreed with Child S and Adult B which offered a range of opportunities.

Some sessions were due to commence in September and some not until November 2008. Included on the timetable was:

- Work experience at hairdresser's salon for one day a week. This was felt to be initially successful.
- College1 courses including hair and beauty and floristry. When Child S attended this was felt to be successful. However, there is no record held by the college of a floristry course being arranged for Child S or her attending one. College1 taster courses were felt to be quite successful but again there was an attendance issue.
- Weekly learning mentor input. The learning mentor could not recall having a set session arranged with Child S or ever seeing the 2008 plan or attending College1 to discuss Child S
- Connexions – social development and basic skills.
- Vacant sessions to be spent at School1.
- Pupil support team which Child S attended poorly.

The assistant head at that time informed the IMR Author that it was the responsibility of the school to review Child S's progress during this period and representatives from the school are said to have visited College1 to discuss Child S's progress. Visits were limited to prevent issues arising for Child S. There is no documentation to support the school reviewed Child S's progress and the outcome of the adapted timetable. For the sessions not timetabled the responsibility for Child S attending the School1 it was believed, by the school, rested with Adult B.

Whilst the records available for the IMR author to review are limited, discussions with staff identified a difference of view about Child S with the head teacher seeing her behaviour as not extreme for one of the school's pupils but more non-conforming. The school were aware that Child S was on the child protection register and then identified as a child in need. It is reported that the head did not agree with the social worker when the child in need case was closed in 2007. Her concern was that the family was still in crisis and asked for her concerns to be minuted. The head stated that no one from outside the school had informed her of any safeguarding concerns. However, there were two issues in July 2007 when the police were contacted about Child S's abuse of another pupil and in January 2008 the school raised concerns about Child S's sexualised behaviour to boys who 'dressed cool'. The school were said to be concerned about Child S's lifestyle, drinking, smoking and Adult B reported she was experiencing violence from Child S [REDACTED]. The School also attended and received copies of the child in need minutes and in July 2008 the Child Protection Conference concluding report was sent to the school.

Whilst the then assistant head stated that during the last two years Child S was in school she presented as a teenager with significant problems, personal, relationships, literacy and numeracy. He stated that in 36 years of teaching he could not remember a pupil who felt so strongly about and embarrassed by attending a School1. She was said to seem to struggle in every area academically. Her abilities were low as her ability to read and write was so limited. Whilst her ability was felt to be an obstacle superficially this was not felt to be obvious.

Child S' learning mentor appears to have had a good relationship with Child S. She feels that Child S trusted her but was guarded and that few pupils are as disengaged as Child S was. The learning mentor felt that outside school other influences took her over and that Child S had very low esteem. Her feeling is they could have done more for Child S in her final year at school.

There was a different approach made to Child S by College1 from 2007. Their assessment of Child S was that she was a quiet child with poor interpersonal skills but that overtime her speech and personal appearance improved. College1 paired Child S with a buddy to help to support her. Child S was liked by the lecturer. Child S was said to seek approval for what she completed. Child S was said to have behaved well and get on well with other students. Child S was functioning well both in hairdressing skills and social teamwork. She progressed so well during this period that her attendance was increased to one day. The only issue for the College1 was her attendance usually after a break. College1 was not aware that Child S was also attending a work placement at a hairdressing salon.

The IMR author established that the role of the College1 placement was to develop Child S's social and communication skills. College1 contacted the School to inform them of absences and also when Child S had done something positive as well. There is record of this on College1 files but no record held at the school. A support assistant from the school visited College1 to discuss Child S's progress and attendance and this in turn was reported back to the assistant head. There is no record on the school file.

During the academic year 2008/9 Child S attended College1 as identified earlier as part of the School Links Infill Daytime Course. College1 contacted the school to inform them of Child S's absences. In January 2009 College1 contacted the school to inform them that Child S had not been seen since November 2008. Two further emails were sent to inform them that Child S was still absent. College1 have copies of the emails sent and are available on College1 files but not on

the school files. Child S' rate of attendance identified by College1 was 35.3%. This compares with the schools records which show an attendance rate for Child S of 86%.

In 2009 after leaving school Child S was registered at College1 to attend:

- Learning support from Learning Support Assistant
- Skills for business and retail
- Individual targets-literacy
- Individual targets -numeracy

The lecturer said that during the time Child S attended college she was attractive and well dressed. She was very proud of her handwriting although she could not read it.

Child S commenced College1 on 7<sup>th</sup> September 2009. Following the absence of Child S on the afternoon of 24<sup>th</sup> September College1 began to monitor her attendance closely and records show that each absence was followed up by numerous calls to Child S or Adult B. Child S's absence during November 2009 escalated and calls were met with information that Child S was sick. The lecturer then discussed with Child S about her having a reduced timetable but Child S did not want this reduction. On 12<sup>th</sup> November 2009 Adult B informed College1 that Child S was pregnant. It is recorded that the lecturer would conduct a risk assessment with Child S and this was undertaken and that the support required enabling Child S to continue attending college would be developed. An individual learning plan was developed and a chair obtained to assist her on the course. Child S returned to college on 23<sup>rd</sup> November 2009 and then failed to attend. Eventually at the end of January 2010 Child S was removed from the course as she had not attended. The lecturer checked with Adult B that Child S was receiving the health care she needed.

Child S was then referred to the Centre1 by Connexions. Centre1 is a pupil referral unit which caters for pregnant girls and young mothers. It enables them to continue their education in this small unit which has nursery facilities attached. The centre is jointly funded by Barnardo's and the Rotherham Education Department, with Barnardo's being the registered provider. Funding from Rotherham Metropolitan Borough Council stops when a girl reaches 16 and to address this Centre 1 obtained additional funding to run a Parent with Prospects Course. This course targets girls from 16-19 and includes some literacy and numeracy skills and helps to meet the requirements of young women, not in education, employment, or training (NEETs).

Child S met with a member of Centre1 staff on 1<sup>st</sup> February 2010 to discuss her potential attendance on the Parents with Prospects course. Child S was seen for assessment on 24<sup>th</sup> February and was felt not to be at a level academically that would enable her to undertake the course. Child S was said to agree with this. Centre1 reluctantly felt that they could not offer Child S the level of support she would need. The Teacher in Charge contacted the School1 to discuss Child S and the learning mentor informed the teacher in charge that she did not think that Child S would be able to cope with a child and that it was likely that Adult B would take over. The teacher in charge contacted both Connexions and the teenage pregnancy midwife to share her concerns.

After the birth of Infant A, Child S again applied to attend College1 in September 2010 to re attend the course that she had been withdrawn from. At interview she informed College1 that Adult B would be looking after Infant A. Child S was offered a place and a recommendation was made that she should be in a small group with a personal tutor.

Child S attended College1 but was absent in the second week. On 20<sup>th</sup> September 2010, Child S was in college and working with a learner support assistant. She disclosed to her that she had left home at the weekend taking Infant A and was living with a friend. She stated her friend was living with grandparents. Adult B was contacted who had told her that Child S had had an argument with her over the weekend and had moved out to stay with a friend, taking her 3 month old baby with her. There was also an argument that day between Child S and her friend. As it was felt that Child S's behaviour was threatening she was warned that it could become a police matter. She was warned about her behaviour and informed of the college disciplinary procedure.

Child S's tutor was concerned about the safety of Child S and Infant A and referred Child S to the designated safeguarding manager (DSM) who contacted Child S and took prompt action as Child S stated she would not return home. He believed that Child S could not identify the risk or implications for her and her baby by the action she had taken. Child S said that she did not know the surname of her friend but had left Infant A with her. The designated safeguarding manager assessed correctly the risk to Child S and Infant A and with Child S's agreement:

- Gave Child S appropriate Rotherham Metropolitan Borough Council telephone numbers for support or emergency housing
- Contacted the Children's Social Care Access team to refer Child S and spoke to the duty officer. The conversation was followed up by an email. Having not received a response by 21st September he contacted the access team again and was told that a social worker had not been allocated and to contact the Team Leader if he wanted to discuss it further. He felt this was not satisfactory and tried to contact the team leader unsuccessfully. He left a message and again followed this with an email. He also attempted to speak to the locality manager but was unable to do this and left a message for contact. At this stage he decided to contact the RMBC Safeguarding Children Unit to share his concerns. The officer advised that he should refer Child S to social care. And to send the details to the assistant Safeguarding Manager, to facilitate discussion. He did as advised.
- Kept Child S informed of the actions he had taken and the outcome by telephone and although Child S was not in College1 the next day she had visited College1 to inform them that she could not attend as she could not get child care and that she was going back to live with Adult B.
- He contacted Adult B and she confirmed that Child S and Infant A had returned home. He informed Adult B of his concerns and actions. She informed him that she was going to be responsible for the care of Infant A. Adult B told him that she was finding caring for Infant A difficult. He suggested that she contact student services and social care. Adult B informed him that she was awaiting a visit from the social worker to complete an assessment of the needs of Child S and Infant A.
- He then contacted the locality manager by email to inform her of his conversation with Adult B and to reinforce that an enrichment officer could be provided to support Child S in College if Social Care felt it was helpful. He also expressed that College1 should be kept informed and involved in any multiagency work with Child S. He also updated the Safeguarding Unit by email.
- He contacted Child S's course tutor to inform her and to ask her to monitor Child S's progress. He also asked how the visit by the Social Worker had gone. Child S had not returned to College and the Course Tutor contacted Adult B who said Child S was sick. Child S returned on the 7<sup>th</sup> October 2010. She said she was happy that the designated safeguarding manager was monitoring her situation and that she had some completed

some forms from housing. The course tutor reported this back to designated safeguarding manager and also said Child S was having difficulties sleeping because of Infant A and that her mother could not cope and she had asked if there were any places in the college crèche. The crèche was full and Adult B was advised to contact Social Care. Adult B was also told that the college would examine if additional funding could be provided.

Child S attended College1 for the last day 7<sup>th</sup> October 2010 and the College was informed of her death on [REDACTED]. The designated safeguarding manager attended all subsequent strategy meetings.

### **Analysis of Rotherham Borough Council - Education services**

The IMR author focuses comments on the period September 2008 to October 2010. Rightly there is recognition that there are inevitable connections to what occurred prior to September 2008.

To assess the School2 environment at the time Child S attended, it is useful to examine objective assessment of its performance. To do this an inspection report completed in October 2001 has been utilised. The primary school was said to be of average in size serving an area of Rotherham assessed to be amongst the most disadvantaged communities in England. There were 237 pupils; 109 boys and 128 girls and the school has a 52 part time place nursery. Sixty five per cent of pupils were white and 35 per cent of Pakistani ethnic origin. 53 per cent of the pupils had English as an additional language. The free school meal figure of 51 per cent is much higher than the national average. 124 pupils were identified as having special educational needs, which was much higher than average, and six pupils were statemented. Approximately 60 per cent of the pupils with special educational needs had moderate learning difficulties with 40 per cent having emotional and social difficulties. Pupils entered the school with very low attainment.

School1 is a school for pupils with moderate and complex learning difficulties from across the Rotherham local authority. It opened on its new site in September 2006 for children aged 7 to 16 years of age. All pupils have a statement of special educational need and enter the school with low levels of attainment. The vast majority of pupils are white British and only a very small number are from minority ethnic groups. More than 40% have free school meals; this is above average. When Child S started at School1 the school was in local authority's 'causing concern' category. As a consequence the local authority undertook a formal review of progress. This concluded that there were significant weaknesses in leadership. A new head teacher took up post in September 2004, and was joined by a deputy head teacher in January 2006 and by an assistant head teacher in September 2006. In December 2006 the school was removed from the local authority's 'causing concern' category.

One of the major issues identified by the IMR author is associated with the quality of record keeping at School1 in relation to;

The files received from the School1 the IMR concludes do not reflect the quality required. They are untitled and contain less about Child S's performance at School1 and more about the assessments made of her at primary and junior school. The pupil support file appears to hold little that is recent and taken with the other files give the impression that as Child S became older, the level of input diminished. The IMR had to rely heavily on the staff at interview who could remember Child S. The IMR author has been dependent to a large extent on the testimonies of staff at the School1 rather

than recorded material. Additionally there is a lack of clarity between what has been reported by the School1 and the content of the school files.

What is clear is that the behaviour exhibited by Child S was apparent at School2 although worsened during her time at School1. By the time Child S attend School1 the pattern of her growing disruptive behaviour had been established and the schools response to it changed little.

There is a consistency in the comments of staff that Child S was a pupil who hated the idea of being at a School1, even to wearing the school uniform, travelling on the school transport or even admitting publicly, which school she went to. Her attitude to other pupils was of great concern and she at time was found to pick on the most vulnerable. However, the comments of staff about the level of input from the pupil support team, the frequency of significant events and violent episodes, where she was and what she was doing and e-mails passing between the school and relevant others is not clearly reflected in the recorded material.

The absence of any form of significant events recording in any timeframe not only means that there can be no certainty about the comprehensiveness of the information in the files, but also that the school would not be able to easily gain an overview of what had happened to Child S and make a holistic assessment. The school, it appears, was reliant therefore on the memories of those people who directly knew her and had experienced her behaviour. The assistant headmaster appeared to have the most extensive personal knowledge, but as he has recently retired, this knowledge has gone with him.

The IMR author suggests that there could not have been recognition of the importance of good recording keeping, what constitutes good recording practice, and how it is a crucial element of the safeguarding of children. If that was understood, then there cannot have been any systematic auditing of files taking place or any supervision of the process.

In considering the whole picture, a number of issues, which are unlikely to be mutually exclusive, become evident. The first of these is that Child S has been an increasingly poor attendee at school and there is evidence of it prior to her admission to the School1. While there are indications of initiatives that were tried, it is hard to identify if there has ever been a coherent plan or strategy to address this or to consider how it links to other issues that were going on around her. The approach concerning attendance of Child S seems to have been to put pressure on Adult B to get her to school. On occasion Adult B drove Child S to school but then she left without entering the premises. So by the time Child S reached 15 years of age, when this review period started, a pattern of non-attendance with an unsuccessful response to address the issue by the school was clearly established.

More than one person suggested to the IMR author that Child S appeared to find it hard to resume her attendance after a break, say for a school holiday or the return to the School1 main building after floods in 2007. This is also a behaviour that can be seen to some extent after she began to attend College1, both as a school extension from 2007 and when she became a post-16 student proper. However, despite this pattern being recognised by school staff, there is no evidence that this was ever addressed as a potential contributing issue and any planned 'reach-out' work attempted on it. In fact although there was input from the learning mentor, at times on a daily basis, and she had occasionally visited Child S at home, no sense of an out-reach approach has been identified. The Education Welfare Service could have been engaged to work more closely on this

issue and some of the circumstances that may have been underlying it. However the evidence would suggest that they were never asked to. If the head teacher is correct that a referral was made and not ultimately followed through, then the school should have done so, in entirely the same way that College1 pursued Childrens Social Care Services until they got a response.

Those who recall Child S at her time at the School1 are said not to have an entirely negative view of her, but the main focus of their recollection, other than her attendance, was her behaviour and how extreme it could be. That behaviour would have been very difficult to manage, because it was directed not only at staff, but also at other pupils and the school would have had a duty to them also, both in terms of their education, but also their well being. It would seem that the bulk of any work from the learning mentor or the Pupil Support Team was directed at this issue. The head teacher commented to the IMR author that Child S's behaviour was not extreme, but non-conforming for the most part.

A further and very significant issue was Child S's total antipathy to special education and the School1 in particular. It is unlikely that she was the only one, but both the assistant head teacher and the learning mentor suggested that she was exceptional in her negative reaction. This appears to have been put down to her being taunted by others [REDACTED] but there is little to evidence whether this was ever addressed either in terms of other potential causes or how well she was assisted to come to terms with it. For example, it is clear from reading the educational psychology files that Adult B was initially formally informed that Child S would go to a mainstream comprehensive, with support, and this was subsequently changed to the School1 (or School1, its predecessor). The IMR author correctly identifies that it is difficult to determine the impact on Child S but one can only conclude this must have been terribly distressing for her.

The IMR author recognises that considerable efforts were made by the School1 to help and support Child S and although much of the detail is not recorded, there is enough consistency in the comments of staff to indicate that their efforts were greater than the records suggest. However, as is documented in April 2007, they appeared to get to a point where they did not know what to do next and it seems to show. In addition, they were trying to do it on their own. There is no recognised proactive plan to address and monitor Child S's educational needs as well as her behavioural needs. Without a plan it appears as a collection of reactive separate initiatives. It also has to be noted that, given the way information was recorded at the school, it is not possible to determine if initiatives were progressed and if Child S ever attended them. What is clear is that given Child S's learning disabilities, school attendance and behaviour, there can be no doubt that she was a vulnerable young person, and the fact that special arrangements were made for her, underlines this point. A joint approach that included the School1, Education Welfare, Educational Psychology and possibly others should have been developed, but it never was.

The school appears to have attempted to be constructive in 2007, by having an agreement with College1 so that Child S could attend there for half a day each week to attempt to address her social skills and this appears to have been successful to the extent that it was extended to a full day. By the end of her penultimate year at the School1, July 2008, it seems clear that the school had recognised that an alternative strategy was required to produce any improved commitment to improve Child S's level of attendance and her behaviour. A strategy was established to try and optimise her engagement, whilst offering some preparation for her post-16 years. The mix of proposed arrangements for the 2008/2009 school year, Child S's last in school, was constructive and combined an extension of the college experience that had been found to have some success,

with a period of actual work experience in related hairdressing. In addition there was a period for the learning mentor on a weekly basis. Furthermore, there was a sound attempt to get both Child S and Adult B to make some commitment to it by meeting with them and getting them to sign a contract to gain their commitment. The IMR author identifies that there is a lack of clarity after this point. It is difficult to understand why the Education Welfare Service and the recognised RMBC education services form was not involved and used. To do so would have allowed the school to incorporate all the information that they had on their own agreement, but importantly it would have set out for everyone the important other issues of dates, length of the agreement, action following breakdown, and how reviews would be carried out. The use of the agreed form would have encouraged good recording of all the arrangements that were made in addition to clarity about reviews. Furthermore it would seem that this form was in common usage across the Rotherham Council. It would be a concern if the school were unaware of it and a greater concern if it was deliberately not used for some other reason. For example, when things are not recorded, there is no audit trail and accountability is hard to establish. In addition, although the assistant head teacher said that Child S could have attended the uncommitted periods by coming into school and they would have responded positively, the fact that there is no mention of this on the contract or anywhere else seriously begs the question of how certain it could be that this was actually understood by any of the parties. Moreover, it could actually be interpreted that the school was sanctioning the non-attendance and that it had been built into the programme. There is a significant difference between a child being expected to attend school, even if confidence is low, and her not attending, and the non-attendance being sanctioned by a school.

The only plan that is in the file is that below which is clearly inaccurate, because although they say it is possible, College1 have no record of any arrangement being made for Child S to attend the Floristry element of the plan. The school, who should be the primary institution to keep records about its pupils for which it has a responsibility, can produce no evidence that such an arrangement was ever made and as the member of staff most likely to have responsibility to have taken Child S to the activity was almost certain that she never had, it would seem that this element of the plan may never have happened.

Day	Period1	Period 2	Period 3	Period 4	Period 5	Period 6
Monday					Learning Mentor Input	
Tuesday	Work Placement from Nov					
Wednesday	Waiting for Connexions confirmation					
Thursday				Hair and Beauty	Hair and Beauty	Hair and Beauty
Friday					Floristry College2	Floristry College2

While it is entirely possible that Child S may not have attended the planned mentoring session, the fact that the learning mentor at the time, who had a single weekly slot on the plan, could not recall

ever seeing her during her final year or the plan again casts its accuracy into doubt and the robustness of the support system that was supposedly put in place

There appears to be little doubt that Child S did attend a work experience placement at a hairdresser in Rotherham. Although the assistant head teacher said that he kept the placement under review, he did not record any of the review information. The fact that other staff could recall visiting the placement and reporting back verbally to the assistant head teacher, suggests that some sort of 'reviews' did take place. As the staff who did visit both said that Child S was not present at the time, but had done so and that the proprietor was pleased, does suggest that the placement was supervised and also that Child S did have attendance problems. It is therefore not possible with any certainty to objectively assess the success or otherwise of the placement or what the salon understood the review arrangements to be. There are no reports, accounts of telephone calls or e-mails on file and the head teacher was unaware of anything other than that on file. While it could be argued that the assistant head teacher had his own personal overview, the lack of recording indicates that the school could not.

Perhaps of even greater concern is the way in which the placement was set up. Although Project3 is an organisation who, amongst other things, finds work experience placements for young people and checks health and safety issues that is all it can reasonably be expected to do. Child S was a vulnerable young person, defined by her learning disabilities, reducing school attendance and engagement and the fact that this whole programme was being set up. In setting up the placement, the school needed to ensure that the placement was safe for such a young person, well beyond the health and safety issues. In order to safeguard her fully, a risk assessment should have been undertaken and recorded. Its absence on the file and no mention of it by anyone is taken to mean that one was not completed and this would have left Child S at potential risk.

Much the same would appear to apply to the time which Child S spent on the hair and beauty module at College1. There is evidence at College1 of e-mails from the link lecturer to inform the school about attendance or lack of it. College1 cannot be sure whether those they produced for this review are comprehensive, but as it was the school that had prime responsibility for Child S, it is they who should retain the records at this time. The impression gained from the assistant head teacher was that he also reviewed progress at College1. This may be correct, but no record exists and the link lecturer at College1 does not recall seeing him during that 2008/2009 year. It would seem therefore that the oversight of the arrangements was not undertaken with rigour. Of particular surprise was the lack of knowledge on the part of the hair and beauty lecturer that Child S was having work experience at a hair salon and it is hard to understand why the School1 would not have mentioned this or made the link. There would have been the opportunity for some potential joint work between the two. It seems a potential opportunity missed.

It is of concern that the school register at School1 indicates that Child S was educated off-site for the whole of 2008/2009 and with the exception of enforced closure of the school and an unagreed extended family holiday, is marked as present, giving her an attendance of 86+%. It is known that this is not true, because staff who did visit the hair salon say that she was not present and College1 also reported that she had periods of absence. College1's own records give her an attendance of 35+%. The school register appears therefore not to be in accordance with local and government guidance.

This means that during 2008/2009, the plan never fully materialised and was poorly co-ordinated. There is no record of what Child S was actually doing and if and when she was doing it. Furthermore, there is no record of the arrangements for its supervision and review and whether such reviews took place and what the outcome was. Of possibly more concern, the School1 did not know on any particular day what was happening. The argument that it was her mother's responsibility to make sure that she attended is not without validity, but that did not absolve the school from its own responsibility in setting up arrangements to monitor the attendance of a child who was still of school age and the clear responsibility of the School1. Adult B could not be held responsible if she believed that Child S was at college or work experience. While the school could not know her whereabouts, they could know if she was where she was supposed to be. The assistant headmaster would have been correct that had school staff been regularly visiting College1, this would have been an issue for Child S, who may have felt less motivated to attend. However, school staff did not need to turn up, they could have asked the supervisor to telephone or e-mail any non-attendance and any discussion could have taken place on the days that she was not programmed to attend. This should then have been recorded.

The reasons for this situation are not easy to determine. It is not known if the poor level of recording is commonplace, as no other files were seen by the IMR author. One interpretation would be to suggest that School1 had stopped caring about what happened to Child S and were just pleased that she was off site but the motive behind the off-site arrangements was well founded and it was the planning and evaluation that lacked rigour. The IMR author suspects that there was a low confidence that it would work and that there was nothing left in terms of ideas and no plan b. This was probably why the school were pleased that she moved onto College1 and still had a chance. It would perhaps be an overstatement to suggest that Child S had become lost to the school, but she appears to have been fading fast. The school also appears to see its remit stopping at the school gate, with little evidence of out-reach work. This was a lost opportunity to work with other agencies to ensure an effective assessment and joint action plan.

There is perhaps a paradox here, considering the concern expressed by the head teacher at her meeting in September 2007, that she considered that Child S came from a family in crisis. Furthermore, Child S was a vulnerable young person and as both the assistant headmaster and the learning mentor, who both appear to have known her very well, suggest that she was exceptional, and also as it has been suggested that she had developed strategies to cover day-to-day manifestations of her disabilities, then perhaps she was even more vulnerable than she appeared. This raises the equalities issue of a young person with disabilities and whether this was recognised. Given the evidence, it would suggest that it was not.

While it is acknowledged that the person who was overseeing these arrangements was an assistant head teacher and therefore a senior person in the school, it does beg the question of what management supervision regime was in place. If the assistant head teacher was being supervised, then it implies that the head teacher concurred with the way things were being run. If the head teacher did not know about them, then the efficacy of management supervision system has to be in question.

The review period falls between the two OFSTED school inspection reports. Both are positive and constructive. The most recent, which took place a year after the alternative curriculum was instigated, is either not reflected in the experience of Child S or is a positive indication that the support regime to struggling pupils and partners is improving. On the basis that it was suggested

by the learning mentor that there have been improvements during 2009/10, such as recording by the Pupil Support Team being more regular and systematic, hopefully it is the latter.

The experience at College1 appears to have been different, or at least in part. The first year tutor would have known about the attendance problems as she had been going to the college for two years previously and the attendance issue had been clear at that time. Despite this College1 felt that Child S was worth a chance. The head teacher of School1 seemed confident that the assistant head teacher would have discussed Child S with the college in his contacts with them, but the first year tutor had no information about Child S's background or the context of her poor attendance or behavioural difficulties.

The choice of course is interesting, but it was Child S's choice. She had shown some potential with hair and beauty, but business studies for a young person with Child S's level of numeracy or literacy does possibly suggest a built-in weakness. However, the addition of extra tuition to support these learning areas was a constructive move.

College1 say that they normally only allow a student three unauthorised absences before withdrawing them. It is not possible to know how rigorously this is followed up with the average student or whether the experience of Child S was associated with her own history or typical for all students. However, almost as soon as her attendance problem began to show, Child S or Adult B was contacted and action recorded and taken. When Adult B disclosed that Child S was pregnant, the college responded appropriately, not only with improved seating arrangements, but a risk assessment to try and protect everyone. In fact the college continued to show interest and encouragement for two months before coming to the conclusion that they had to withdraw Child S from the programme. By that time anyone would have had difficulty in reintegrating back into the course, but for Child S, it was more difficult as she had shown that she found returning after a break particularly challenging. College1 say that they did check with Adult B that Child S was receiving appropriate health care. Given Child S's background, it is possibly worth questioning whether they should have referred her on to the NHS to be doubly sure, but they did not have a great deal of background information about her, had no reason to doubt the word of Adult B and they would have needed the permission of Child S to do so, as she was over 16 years of age. All of this information was recorded on the college files, available not only to this review, but others who might have assumed some level of responsibility for her.

It is also worthy of note that College1 became aware of Child S's pregnancy, due to their persistence in following up on Child S's absence, which in turn was based on their knowing that Child S was not attending. This is a marked difference of approach from that of the School1.

It is arguable that the college might justifiably not have accepted a further application from Child S, but given the circumstances of her pregnancy, their belief that some students can change, and their apparent recognition of Child S's vulnerability, it was to their credit and Child S's potential advantage that they did. Having said that it seems that they were very direct about the difficulties ahead and had no reason to question Child S's assertion that her mother would care for the new Infant A, a situation that is not uncommon in families. A further indicator that they recognised her needs was the small tutor group recommendation.

The new term in 2010 had hardly commenced before the problem of Child S leaving home with her baby occurred. At this point the college appear to have produced an almost textbook approach to

dealing with the issue. However, in addition to exercising their safeguarding role, they also demonstrated their duty of care, not only to Child S, but also Infant A. The most encouraging thing was that Child S, who had a history of being cautious about what she told people, was prepared to tell the learner support assistant which would indicate a high level of trust on the part of Child S. It is not possible to assess whether this was to do with the college approach, the learner support assistance herself or both. Had Child S continued at the college, this relationship at least showed some promise. In turn the support assistant recognised what she was hearing and appropriately reported it on to Child S's tutor, who in turn appropriately reported it further to a senior level and the designated safeguarding manager for the college.

The designated safeguarding manager checked the facts directly with Child S and then made arrangements to ensure her and the baby's immediate financial requirements were met, requirements that Child S did not appear to recognise for herself. The information given to Child S about the place to contact about her housing needs was, was both timely and appropriate. The situation was then appropriately referred to social care and followed up in writing, which should have ensured that the referral was logged in the system. College1 at that stage could have left the matter in the trust that it would be progressed. However' they continued to demonstrate their duty of care, by following it up, and again in writing, until they received some confirmation that action was being taken.

This approach was again demonstrated when Child S's tutor kept in touch with Adult B and tried to organise some relief for her in the care of her grand-daughter. While this was no doubt aimed at optimising the chances of Child S continuing to attend College1, which is commendable in itself, the college did appear to maximise their remit in endeavouring to get a positive outcome for the family, and do not appear to have interpreted their responsibility being limited to the college entrance. Interestingly, both Child S and her mother made at least two recorded comments to different College1 staff, that Adult B would be caring for the new Infant A. There was therefore no assumption on the part of the college about this, they had been told by both the people involved.

There is evidence that the college also saw the possible longer-term outcome as being dealt with in a multi-agency forum and saw its own part in that outcome. Of particular interest was the offer of an enrichment officer to provide support for Child S to develop her maturity and address her behaviour issues. This might have been helpful a year earlier, but there is no evidence that the college were aware of other issues than attendance at that stage.

The College1 OFSTED report of November 2010 would appear to largely reflect the findings of this review with respect to Child S and therefore imply that other students receive similar support and protection.

It would appear that Centre1 may have been able to assist Child S in different circumstances and if her skills had been at a higher level. This would however only have been because funding from an alternative source had been attracted. Had mainstream funding been available, and then it is possible that Centre1 might have had the resources to deal with Child S's low numeracy and literacy issues and assist further in preparing this very vulnerable young woman for parenthood, both to her own advantage and ultimately that of Infant A. Although it cannot be said that this contributed to any lack of safeguarding of Infant A, it certainly did not enhance it. Centre1 did however recognise Child S's vulnerability, appropriately sourcing material from School1 and passing this on, before closing the case.

## **Analysis of RMBC – Education Services IMR**

The IMR author had difficulty accessing some information because records were missing. However, the analysis of available material is specific, has appropriate timings and the terms of reference are answered. It has been supported by his diligent interviewing of staff some of whom had left the service of the Council. The IMR author has used the available information to analyse information effectively. The review is appropriately critical of some areas of practice and handling of incidents for example in relation to the responsibility of the schools for the supervision of Child S whilst she was undertaking off site learning. The recommendations reflect key issues.

### 3.3 Youth and Targeted Services (now Children's Community Services)

The IMR is an analysis of the involvement of both Connexions and Young People's Services (Project1) with Child S from 2004 to 2010. The IMR author has had difficulty developing the IMR as a result of a lack of available information. The account of involvement of the agencies has been developed using what is available and by interviewing key staff. The analysis of involvement of the services with Child S makes reference correctly to the issue of information management.

To enable this service to be set in context a description of the development and role of Project1 has been provided. Whilst the IMR describes the limited involvement that they had with Child S, in many ways the role of this service was pivotal in the multi agency perceptions and resultant response to Child S's vulnerability in relation to sexual exploitation.

Project1 is based within Young People's Services and is a standalone project within the Youth Service. Established in 2000 the original aim of the project was to provide preventative services for young women at risk. However, over time they have evolved into a much more active role in supporting young women both at risk of and involved in sexual exploitation and providing information on alleged perpetrators. It is important to recognise that young women volunteer to work with Project1.

Rotherham Young People's Services has been awarded the Youth Service Quality Mark by the National Youth Agency. This is a national award in recognition of outstanding services for young people.

The development of Project1 has not followed a coherent path in response to the sexual exploitation of young women in Rotherham. Rather it has been driven by a number of factors both reactive and proactive. Its development was influenced by the Rotherham's responding to the *Sexual exploitation of children and young people* action plan in 2006.

The project was initially established as a response to youth workers who in the late 90's began to identify young women who were alleged victims of sexual exploitation. Initially the response was limited with a number of youth work hours dedicated to work within schools to provide preventative work. As perception of need grew within the Youth Service a small project was established with a steering group with the Youth Service and voluntary sector members working together to provide governance and a source to establish additional funding.

The IMR author identifies that Project1 was first involved with Child S and her family in September 2004 and continued to maintain some involvement until the end of the terms of reference for this review (12<sup>th</sup> October 2010). However, for the period identified in the Terms of Reference as the specific focus for review (1<sup>st</sup> September 2008 until 12<sup>th</sup> October 2010) there was no direct contact with Child S as the case was closed.

At the child protection conferences in November 2004 [REDACTED] behaviour was discussed and concerns were voiced that Child S might be influenced by [REDACTED] behaviour and lifestyle. Project1 involvement was initially with [REDACTED] regarding concerns that she was at risk of involvement in sexual exploitation. The social care records indicate that Project1 was not

represented at the case conference. The recommendations from the conference related to Project1 and the family were:

- Information that [REDACTED] and Child S were to be placed on child protection register in the categories of Sexual Abuse and Emotional Abuse.
- That the Social Worker should liaise with Project1 and request the service to undertake keep safe work with [REDACTED] and Child S.
- Additionally that the core group would promote family activities for Adult B, [REDACTED] and Child S.

There were two specific tasks for Project1:

- To attend monthly core group meetings on [REDACTED] and Child S.
- To link with Child S and try and engage [REDACTED]

Subsequently on the same day as the conference a referral was made from the Social Worker to Project1 to undertake Keep Safe work with Child S.

Following this referral during this first period of work with Child S, the IMR author identifies that:

- It was not until 16<sup>th</sup> December 2004 that Project1 made contact with Child S. The reason for this delay is not apparent in case files, but it is reported that it is not uncommon for Project1 to have a waiting list. There are no records or evidence of contacts on case files by Project1 after the 16<sup>th</sup> December 2004 and Project1 report that no further work was done with Child S. There is an impression in the core group meeting minutes in February 2005 implying that contact was still ongoing at that point. However, according to Project1, no further work was undertaken with Child S although work continued to take place with [REDACTED] and therefore there was some contact with Child S.
- The second and third Child Protection Conferences in February 2005 and July 2005 both contain actions for keep safe work to continue with [REDACTED] and Child S. At the Core Group meeting on 29<sup>th</sup> July 2005 an action is noted for a worker from Project1 to be allocated to Child S. On examination of the record the IMR author found that there is no explanation of the contradiction between actions noted in the Child Protection Plan to undertake safe care work and the action noted in the Core Group to allocate a worker. There is no evidence in the case files that this work or outcomes were monitored by the conference or Core Group. There is therefore an unexplained gap between the decision of the first Child Protection conference to "link" with Child S and engage [REDACTED] and contact ceasing after one visit and re-referral in July 2005.

Project1 continued to be involved in Child Protection conferences until the de-registration of [REDACTED]

- The next recorded contact for Child S with Project1 is in August 2005. After which there were a total of 8 face to face contacts made between August 2005 and June 2006. These were mainly for activities and to encourage Child S to attend a youth club. On 6th June 2006 the case was closed as a result of Child S's lack of engagement. There is no evidence of Child S being referred to any other agency.

- On 5<sup>th</sup> June 2006 a report was sent from Project1 at the request of the then Director of Social Care who was also chair of the Sexual Exploitation Forum. The report contains lists of names of young girls believed to be at risk of sexual exploitation including Child S and [REDACTED]. It is also the first attempt to quantify levels of risk by assigning levels of 1 – 5 to young women believed to be at risk. Any outcomes from this report are unclear. On 26<sup>th</sup> July 2007 there is further attempt to quantify risk in a report to the Head of Connexions who was chairing the Sexual Exploitation Forum. Again risk is graded into levels, this time from 1-3, and Child S and [REDACTED] are cited alongside other girls at risk.
- There is no further contact with Child S until the Connexions worker at Project1 was allocated the case in response to a referral from Social Care on 8<sup>th</sup> April 2007. It is not until 4<sup>th</sup> October 2007 that contact is made with Child S. Again this six month delay, from records, appears to result from workload pressures as there no space available to be allocated. There are 8 face to face contacts from 8<sup>th</sup> April 2007 until contact stops. The IMR author does not identify if there is any indication of this situation being addressed by service managers or the Core Group considering how to work with Child S during this period. There is one assessment of Child S in 2007 prior to the Connexions worker attached to Project1 beginning to work with her. However, this focuses on risks posed to the worker and is a specific template designed for this purpose. There is therefore no focus on risks to the child.
- During October, November and December 2007, contact is maintained with Child S and the majority of work takes place in school, and is based around the Safe Care booklet used by Project1. Although there is no evidence on file that the learning difficulties of Child S were accommodated, it was established by the IMR author that the Connexions worker attempted to work with Child S using a variety of media images, artwork, writing notes for Child S to copy and that the safe care work was incorporated into these activities due to the slow pace and limited engagement with Child S. Direct contact work with Child S appears to have ceased in March 2008.
- For the period of the focus of the review (1<sup>st</sup> September 2008 to 12<sup>th</sup> October 2010), Project1 has no direct contact with Child S. The IMR author also identifies that there is indirect reference to Child S which appears in Project1 files from 9<sup>th</sup> September 2008 beginning with a note that Child S has an Asian boyfriend.
- The rest of Project1 involvement is associated with the provision of information. And includes:
  - In September 2008 telephone calls are received from Social Care requesting information about Child S and [REDACTED] in relation to a child protection matter, which is not disclosed. According to telephone records maintained at Project1 the case is then closed because Social Care has the wrong address for the family.
  - In November 09 and December 09 reports are sent to South Yorkshire Police. The November one containing concerns about an older man who is allowing young women to spend time at his address. The report in December is a duplicate of some of the information contained in the report to safeguarding, and concerns young women at significant risk of sexual exploitation in the Place1 area of

Rotherham. Both Child S and [REDACTED] are referenced as associates of young women involved in sexual exploitation and / or associates of men alleged to be involved. Child S and [REDACTED] are also cited in a list sent from Project1 to the Police and Social Care headed "other young people at risk of sexual exploitation".

- On 19<sup>th</sup> January 2010 an email was sent to the safeguarding team informing them of an incident on 16<sup>th</sup> January 2010 in which it is alleged by a young woman that two Asian males threatened another young woman with a gun. This was discussed at a strategy meeting in relation to Operation Czar (See section 2) and it is alleged that Child S was also threatened with the weapon. Child S was included in a list of adults and young women of concern to the operation. It is surprising that there was no specific actions related Child S but an overall action was recorded for all young women identified at risk to be assessed by Social Care. It is not clear from this or subsequent meetings if this was achieved and the outcome.
- Strategy meetings for Operation Czar continued in February and March 2010. In February Child S is referenced as pregnant and concerns expressed for her safety. No actions were identified specifically to Child S and her unborn child although the need for risk assessments on all young people is reiterated.
- At the March 2010 meeting Child S is again referenced as a child of concern. Agreed actions included a pre-birth risk assessment being undertaken, South Yorkshire Police to keep Social Care updated on the gun incident, Project1 and Social Care to meet on 21<sup>st</sup> April 2010 to discuss roles and responsibilities with young people and Social Care to review all young people with regard to thresholds for child protection conferences. It is unclear if these actions were carried out in relation to Child S.
- The last entry of relevance in Project1 records is the meeting with Social Care noted above on 21<sup>st</sup> April 2010. The meeting was between the Locality Manager, the Head of Young People's Services and manager of Project1. The records of this meeting are notes made by the manager of Project1. The notes identify that in relation to Child S Social Care would continue with assessment of her unborn baby, but there is some disagreement about the level of risk posed to Child S, with Social Care feeling there were no sexual exploitation concerns with regard to Child S and Project1 feeling she was still at risk. This appears to have been resolved by a compromise between Social Care and Project1 in that Social Care would not allocate Child S but would refer via the social worker for Project1 to provide support. There is no subsequent evidence that this was done.

### **Issues related to Information Management**

The issues identified by the IMR author in relation to the management of information by Project1 are;

- That there are only three Core Group meetings evidenced on file despite them occurring more or less monthly from 25<sup>th</sup> November 2004 until the de-registration of [REDACTED] This

is partly a reflection of minutes not being circulated and there is no indication that this was followed up. This is evidenced by the minutes of the conferences that record attendance by Project1 staff.

- In addition to the paper files there are two computerised databases. The first is EYS the Youth Service Activity Database and the second is an internal Access Database. The EYS system records mainly activities undertaken with young people and attendance. Whilst there is the facility to record contacts on the database, Project1 do not use this as the database is open to everyone in Young People's Services. The project contacts are anonymised, in order that young women are not identified by others as being at risk of, or involved in sexual exploitation. The same format is used for other confidential services within the Young People's Services e.g. counselling services. The Access Database is a new development to make connections between young women at risk and alleged perpetrators. This is in addition to the paper based system. The database includes both Child S and [REDACTED] and links them to alleged perpetrators, details of vehicles used, telephone numbers and addresses, and other young women associated with them, or any of the other categories. The database does not include the context for information, the source, or any weighting in terms of risk. Project 1 staff report that the police find this database extremely useful, as do staff themselves. In the course of their work with young women they will often come across information that may appear to have no relevance at the time. This may subsequently become significant, in the context of building a picture of child sexual exploitation in Rotherham, following further information or the referral of a child.
- Direct work with Child S begins on 4<sup>th</sup> October 2007 and is undertaken by the Connexions Personal Advisor (PA) for Project1. Details of contacts on the Connexions database are sparse, but are duplicated in a little more detail on Project1 records. At this time it was apparently the practice to keep minimum records on the Connexions database if young people were open to the Project1 PA. The purpose of this is to maintain confidentiality about the work undertaken in relation to sexual abuse. A similar practice is adopted in relation to EYS (Young People's Services database). Whilst some dates do not match between the two systems, Connexions system and Project1 case files, where there is a mismatch the content of the record is accurate to within a few days. This is to say the type of contact is consistent and the activity undertaken. This is taken as an administrative or recording error.
- Records for the period prior to the main focus of the review are concerned with alleged associations of young women either with each other or with alleged perpetrators of sexual exploitation / abuse. The records are again handwritten and consist of statements of information of varying specifics, e.g. "X has a gun which is kept under the passenger seat" or "X is associated with Y who is known to Z who has had sex with V". Whilst both Child S and [REDACTED] feature in some of these accounts, how this information can be interpreted by this review is problematic as no context or sources are cited and no weighting of risk is given. At interview the IMR author was able to establish that the staff at Project1 could usually be clear about the source of the information, but information pertaining to Child S is all second and third hand and from single sources and therefore unverifiable. For the purpose of this review it has therefore been discounted. Staff are adamant that they share

all information with the Police and Social Care, and there is evidence of this elsewhere in records

### **Analysis of RMBC Youth and Targeted Services involvement**

Reading the IMR what is obvious is that there are a number of issues about the way that Project1 functions. The IMR author identifies that

*There is no doubt that the workers and the manager of the project are skilled and passionate at what they do and the project is commended by the "Lesson Learned Review". But in the absence of forms of accountability and governance either from within the project or externally via Social Care or safeguarding there is the danger that young women who are reluctant to engage such as Child S become lost to both statutory and voluntary services.*

Effective practice depends on adequate organisational processes and structures. Assuring the quality of both professional practice and organisational processes and structures depends on robust performance review and quality assurance systems. This contributes to confident accountability internally as well as informing external requirements such as national performance indicators and inspections. Project1 does not have in place the processes and structure required and there appears to be a lack of performance assessment.

The first group of issues identified by the analysis relate to organisational structures and include:

Project1, the IMR author identified, began in 2000 to meet an acknowledged need. There is no available evidence that a project plan was produced or that a performance framework was established to assess the outcome of the services which in turn would facilitate reconfiguration of the service to meet changing need.

As noted previously the Project1 began as a small preventative project which has grown to work with young women directly involved in sexual exploitation, played a pivotal role in police operations, and collating information about alleged perpetrators. Over time due to a number of factors it moved from prevention to a playing a role in Child Protection. Its resources and systems have not grown at the same pace and the Service is inadequately resourced, recording systems are maintained by handwritten notes and the project has very little administrative support.

This asymmetric growth has also evolved into a type of case management with individual workers supporting young women, and maintaining case files on them. In keeping with the ethos of a youth service, work with young people is voluntary and proceeds at the pace of the young person. The growth and change of role of the project coupled with its location within the Young People's Services means that there is no culture of case management, supervision or oversight of the type to be expected in Child Protection. Neither does there appear to be at the time of engagement with Child S effective risk assessment or planning.

There appears to have been a lack of consideration of the difficulty experienced of adapting organisational structures and gaining the commitment and acceptance of other professionals. Introducing a new programme provided by a practitioner with an enhanced role into the existing

local safeguarding structures requires the whole system to consider roles and responsibilities and the policies and procedures that underpin practice. Glisson and Hemmelgard (1998) state that effective joined up working requires a supportive policy and managerial context. Procedures and policies are solid representation of joined up working.

The IMR author identifies the challenges created by different 'Communities of practice'<sup>23</sup> recognising that Project1 having its origins in youth work was initially driven by a perception of need, its ethos and culture is embedded in supporting and enabling young people. The "Lessons Learned Review" following Operation Central notes that in 2008 Project1 was "well placed" to support the "gathering of evidence process for prevention and prosecution purposes" (6.3.3) and "..... *It appears that cases have been referred to Project1, as an alternative to Social Care supervision, and it has risen to that challenge*".

The net effect of this is that a service founded in the traditions of youth work, that struggles for resources, has become part of the safeguarding arena but is not part of that directorate. The drivers of this appear to be the enthusiasm of Project1 staff to deal with this problem, from working with these young women for a number of years, their expertise noted in "Learning the Lessons Review" (2010), and their ability to collect and collate a wide range of data on young women at risk, as evidenced in the Access database. This is coupled with a growing awareness amongst statutory agencies that child sexual exploitation is a real problem in Rotherham. Both the manager of Project1 and the Head of Young People's Services reported to the IMR author that funding for the service has been a perpetual problem with both external funding and revenue being utilised at different periods. Consequently staffing levels have fluctuated for a number of years and currently stands at 1 manager, 2 full time equivalent staff and a Connexions post. Some of the delays in meeting with Child S and waiting list are as a result of a lack of capacity.

The question has to be asked if there was a managerial and risk assessment of Project1 which identified the resource and workforce capacity and capability to undertake this changed role. It remains a Youth Service project that does not have the rigour of case management supervision, procedures, and systems that might be expected within the child protection system. Its competence therefore as the "Lessons Learned Review" observes is spread "too thinly in order to be the solution to all things CSE" (6.3.7).

Governance arrangements have been changed over time with the steering group becoming a "Key Players Group" then the "Sexual Exploitation Forum", and finally merging into the current arrangements. But they do not address the fact that Project1 does not sit within the safeguarding framework and as such is not seen as part of mainstream safeguarding services.

The Head of the Youth Service acknowledges this situation and feels the service should be re-focused back to its youth work / prevention role with clear roles and responsibilities. The service still maintains its preventative work within schools and this is apparently well received in that schools continue to be willing to fund this. This work is subject to evaluation via feedback forms from participants and forms part of a local award scheme that is independently credited. The gradual transformation into direct work with young women at risk of sexual exploitation means that this expansion has been organic rather than structured, consequently no business case has been established and there is no evidence of any evaluation or audit.

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<sup>23</sup> Etienne Wenger (1998) Communities of practice

The IMR author identifies that the system of recording at the project requires urgent review as does the practice of not recording on various electronic databases. The Access database used at the project has limitations in terms of size and number of fields that can be entered. It will also be subject to the Data Protection Act and it is not clear at present if it would comply with this legislation.

There are significant risks created by the fact that there are no written assessments or care management plans and that all records within Project1 are handwritten, often not signed or dated, and the filing system reflects their priorities with individual files being held on young women open to the project, alleged perpetrators, and also in the case of activities such as Operation Czar, files devoted to that particular operation. Whilst this appears to be understood by the staff of Project1 it is confusing for those unfamiliar with the process, consequently the narrative of Child S is difficult to obtain. Within the period of focus for this review Project1 had no direct contact with Child S and records are limited to third party information from Operation Czar, a child protection query from Social Care and alleged associations with other young women involved in sexual exploitation or alleged perpetrators.

Prior to the period of focus there are two referrals to Project1 for Child S. One generated from the child protection conference on 18<sup>th</sup> November 2004 to undertake safe care work, and one on 18<sup>th</sup> April 2007 from Social Care again to undertake safe care work. In neither referral is "safe care work" defined but the project staff takes it to mean the work they undertake with young women as part of an accredited award. The project has developed a booklet containing paper based exercises they work through with the young women. This is retained by the young women so there is no evidence of work undertaken in the files. Neither is there evidence that the project has taken account of the learning difficulties of Child S, other than in interview with the Connexions PA noted previously.

Altogether there are sixteen face to face contacts with Child S, eight for each referral. Other contacts are made by telephone in an attempt to engage but Child S was reluctant to participate.

There is no evidence in case files of management oversight or individual supervision. The project says that project management oversight is via one-to-one contact meetings they hold as a team chaired by the manager (although there is only evidence of one of these in the case of Child S). The project manager follows the supervision procedure of Young People's Services which is located within a performance and development framework and primarily concerned with staff performance and training. There is consequently no mechanism for professional supervision of cases. For the majority of staff within the Youth Service (i.e. youth worker's and detached street workers) this will be appropriate but is flawed when youth workers are intensively supporting / holding cases. The Head of Young People's Services accepts these observations and points to the asymmetric growth of the project and the findings of the Learning the Lessons Review.

There is little direct reference to Adult B or Infant A and therefore no conclusions are drawn about assumptions that Adult B was the primary cover of Infant A. Similarly conclusions cannot be drawn from the review of Project1 about the parenting of Child S or contributions to the genogram.

There is no evidence of any risk assessment being conducted on Child S in relation to her alleged risk of sexual exploitation, although there are two attempts to define risk via reports to senior

management. These attempts at quantifying risk do not appear to have been subsequently embedded in the project's work.

There is evidence of information sharing by the project both with the Police and Social Care, and those interviewed at Project1 and Connexions are confident that they share everything with the Police and Social Care. However there is no context, source or weighting given to the information that is shared. The onus is therefore on the recipients of that information how they perceive it. For the Police this may not be a problem as they are adept at this kind of soft intelligence gathering and will have other sources to draw upon to verify information received. The Project Manager reports that the police would prefer to receive information in this way as it assists them in gathering evidence in association with other information they hold.

It is possible to infer from the various minutes of Operation Czar that safeguarding meetings focussed more on securing evidence than on particular individuals at risk. Child S becomes salient in the minutes in relation to the gun incident but reverts to her previous status of a "child of concern" once she refuses to give evidence. Although there is no reference to the eventual outcome of this incident, and it is not unreasonable to assume that this should have increased concerns sufficient to raise Child S within the thresholds of child protection. At the time of writing this report no person or persons have been convicted in relation to the death of Child S and the police investigation is still ongoing. It may be therefore outside the purview of this report to speculate at this point. However in previous reviews / enquiries of cases where people have met with violent deaths e.g. Bichard 2004<sup>24</sup>, London Criminal Justice Board (2009), there has been instances of violent behaviour on the part of the perpetrator that have been overlooked. Should the individuals involved in the gun incident subsequently be those convicted, and then this will be a critical point for lessons to be learned.

The staff at Project1 do not see their role in sharing of information to be one that involves the disclosure of source or context, and reference a clause in Rotherham's Sexual Exploitation Procedures which states:

*"It is not the role of parents/carers or professionals to provide evidence of a child or young person's involvement in sexual exploitation. It is their responsibility to report their concerns that they are involved, using the indicators of risk as a guide. They should also not be asked to seek out evidence on behalf of CYPS Social Care and/or the police". (Section 7.6).*

It should also be borne in mind that Project1 is located within Young Peoples Services and not a statutory service. These observations may therefore be considered unfair. However, with "no clearly defined criteria" Bichard (2004), there is a danger of misunderstandings and tensions developing between agencies and this begs the question as implied in the Learning Lessons Review of whether the project is located in the right place. Further weight is added to this by the conclusions of the Barnados (2011) report on sexual exploitation, "Puppet on a String" which recommends, "it is also vital that that the right specialist services are commissioned and that there are clearly determined pathways from universal to specialist services."

All the staff interviewed were passionate about their work and keen to emphasise the extent of sexual exploitation in Rotherham. They feel without exception they are not listened to by Social

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<sup>24</sup> Report of the Bichard Inquiry 2004 TSO

Care and cited several examples involving other young women. There is evidence of the tension between CSCS and the project of which only one example is found in the case of Child S, the meeting between Social Care and Project1 in April 2010.

One issue that influences the relationship between Project1 and Children's Social Care results from the way in which Project1 collate and share information which is very much embedded in their status as youth workers, and the approach they take to sexual exploitation is similar to that they would take in incidents of anti-social behaviour or the setting up of a youth club - that is, by over time mapping out networks of young people and identifying their needs and perceptions. Whilst this will fit with the intelligence gathering model of the Police it may not necessarily fit so well with the social care model of thresholds and priorities.

It is difficult to quantify the extent that Child S was involved in sexual exploitation, although Project1 believed she was deeply entrenched based on their knowledge of [REDACTED] and Child S' associations with alleged perpetrators and other young women alleged to be involved. However, there is little evidence within the case records to substantiate this. Given the nature of sexual exploitation and the secrecy associated with it, lack of evidence is not necessarily commensurate with lack of exploitation. Agreed and shared risk assessments between the Police, Project1 and CSCS or a multi agency unit as recommended in the "Lessons Learned Review – Operation Central" (2010), would have assisted in identifying the level of risk posed to Child S. It is a missed opportunity that these were not completed as part of the strategy meetings in relation to Operation Czar.

The procedures for safeguarding children and young people from sexual exploitation set out the indicators of risk for child sexual exploitation and are very clear and comprehensive providing the basis for a risk assessment of any young person in relation to sexual exploitation. They also recommend that initial assessments and strategy meetings are held in relation to young people and note that "....."children and young people who are sexually exploited are a particularly vulnerable group who may become "lost" to the statutory agencies due to cases being closed, or delayed action. Particular care and attention is required therefore, when assessing the needs of children and young people who are sexually exploited and considering how best to help them during the initial assessment and core assessment". The procedures are dated March 2010 with revisions noted in 2006, 2009 and 2010. It is not clear therefore what version was applicable during the review period.

The Strategic Director of Children and Young People's Services should as a matter of urgency review the role of Project1 in meeting the prevent, deter and treat <sup>25</sup>needs of children and young people at risk of sexual exploitation and grooming. Robust assessment and decision-making in safeguarding services, in respect of individual families and children, depends on good internal and cross-agency practice that draws appropriately on the most up-to-date knowledge base and must be assessed from the perspective of changes taking place not in the child protection system in isolation, but in relation to the system functioning as a whole. Multi stakeholder governance has been identified as an issue by many reviewers of safeguarding services, including Lord Laming and Professor Munro. There are going to be substantial changes in the structures and staffing of all services involved in safeguarding children, young people and adults and it is crucial that the role of Project1 forms part of this thinking.

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<sup>25</sup> Jenny Pearce Young People and Sexual Exploitation 2009 . Routledge

Any review should consider:

- If the role presently undertaken by Project1 is best provided by that service and that it should be resourced to meet the role and have a workforce who is prepared and supervised to address the three tier category model of sexual exploitation.
- Where the management responsibility sits i.e. in youth work or safeguarding or Children's Social Care.
- How it fits with the role of the full time sexual exploitation co-ordinator and sexual exploitation forum.
- The procedure for use of the service also has to be considered as presently referrals do not go to safeguarding in the first instance. Direct referrals to Project1 results in some at risk children not being known to safeguarding. There is no evidence of risk assessment or prioritisation or the procedure of handling children when they leave the service. In the case of Child S it was difficult to determine when her case was closed and when open, how she was risk assessed and her care planned and reviewed.

### **Analysis of RMBC – Youth and Targeted Services IMR**

This is the first IMR that the author has completed and it has not been an easy task because of the lack information in records. He has however analysed available material well and as specific as he is able to be given the difficulties in appropriate timings and the terms of reference are answered. It has been supported by his diligent interviewing of staff. The IMR author has analysed available information effectively. The review is appropriately critical of some areas of practice and particularly in relation to the management of the service. The recommendations reflect key issues.

### 3.4 NHS Rotherham - General Practice

General Practitioners practice medicine in the context of not being directly employed by the NHS. They provide services to their local NHS commissioning organisation, in this case NHS Rotherham, under the terms of a national contract – there is very limited discretion to vary the terms of this contract. General Practitioners employ their own staff e.g. practice nurses, receptionists etc. This IMR considers the involvement of the GP Practice and their staff in relation to Child S and Infant A.

Of note it is not a legal requirement to register with a General Practitioner (GP) in order to be able to access NHS services, but around 98% of the population are registered with a GP. Child S and Infant A were both registered with the same GP Practice, which is a local expectation of parents and children. In Rotherham it is usual for all family members to register with the same practice of note Adult B was also registered at this practice.

The IMR author identifies that the GP practice that Child S was registered with had limited involvement with her. However, they have correspondence on file that provides the GPs with valuable information about her. The GP records cover Child S' routine general medical care from 1 September 2002 to September 2008. Child S attended the GP Practice rarely but appropriately in this time period. Within the GP records there is detail from other clinical agencies. These include:

- Rotherham Child Protection Conference 8.11.2004
- Child and Family Psychiatric Dept 16.6.2005
- Learning Disability Service 17.10.2005
- Children & Young People's Services 5.12.2006
- Clinical Psychology, Children & Young People's Services up to October 2008
- A letter of referral by the GP in June 2005 to children's psychiatry (Child S 12 years old) detailing the fact that Child S had behavioural problems since the age of 2 is also on file. In view of her learning disability and attending a School1 this was re-directed to the Learning Disabilities Service where she had failed to engage and was discharged from their care. However, in 2008 she had five assessment sessions with the Children & Young People's Services Specialist Support Team.

A letter was received from the clinical psychologist (CP1) in October 2008 which identified:

- Child S's aggressive, erratic behaviour and self harming.
- That Child S did not like attending Special school and Adult B felt she was embarrassed.
- The violent episodes between [REDACTED] and Child S.
- [REDACTED]
- Child S was being bullied.
- To avoid confrontation Adult B was leaving Child S in bed.
- Child S had little contact with her father [REDACTED]
- Child S was said to hate school which led to inappropriate behaviour, Child S worked well at College1.
- The School had devised a bespoke timetable for Child S which had proved to be successful for a time but her behaviour had deteriorated.
- Treatment would include anger management and self esteem work.

- That Child S had been referred to the police and Project1 and social care after a sexual encounter. (Child S was 13 at this stage)
- An offer of family therapy was made to Adult B but refused.
- Referral to the school nurse.
- No contraceptive advice was given.

In November 2008 a further letter was received from the clinical psychologist stating that Child S had not attended two appointments and that if she had not made contact by the end of November she would be discharged. A final letter discharging Child S was received in January 2009. The GP did not follow this up in any way by contacting other agencies or Adult B.

In January 2009, Child S was 16 years old and she attended for a school medical review. A report was developed by the Clinical Medical Officer. This was not typed until 3rd June 2009. The medical review identified that:

- Child S had moderate learning difficulties with an IQ of 56.
- Child S had a statement of special educational needs and had been provided with additional non teaching assistant in 2000.
- Child S's immunisations were up to date. This was not correct.
- There were no concerns about Child S's growth and fine motor movements communication, hearing or vision.
- Her weight was on the 91<sup>st</sup> – 98<sup>th</sup> centile. This means that only 9 - 2 percent of children would be heavier than her at her age.
- A note was made about behavioural problems. She was said to be disruptive particularly if she did not get her own way.
- She was also smoking 10 to 20 cigarettes a day.
- She was in receipt of disability living allowance
- Child S was referred to community dental services
- Leaflets about local exercise groups, healthy eating and learning disability were sent to her home.
- There was no discussion about any sexual encounters. The Clinical Medical Officer may not have been informed by Adult B or Child S about this.

The next communication was from the NHS Rotherham Walk in Centre informing the GP that Child S had attended the centre as her period was a week late and that there was a risk she might be pregnant. The pregnancy test was weakly positive. The letter said that Child S said that she would not be upset if she was pregnant. Child S and Adult B attended the GP practice. Pregnancy tests were positive and Child S indicated that she wanted to keep the baby with the support of Adult B. The records indicate that Child S was told to book a 12 week appointment at the reception with the midwife and that the midwife would need to be made aware that she would need additional help. An earlier referral before 10 weeks to the midwife is now recommended.

There are then 17 references made to the antenatal care of Child S. Of note in the records is that Child S failed to attend for 3 antenatal appointments. This was quickly followed up by the Community Midwife. There is no indication in the notes why Child S had not attended. There is no indication of Child S' feelings in the records throughout her antenatal care. The only problem during her antenatal period recorded on GP records was a urine infection and diminished foetal movements and that the baby was clinically small. There is no outcome of a 40 week review in the

GP records. A text message was sent to Child S asking her to make an appointment to attend for a Measles, Mumps and Rubella booster.

A letter was received by the GP Practice from TRFT informing the practice that Infant A had been born by forceps delivery on [REDACTED] and then discharged on [REDACTED]. The practice was also informed that Infant A had a clicky hip. This was resolved in October 2010 when TRFT paediatrician confirmed that Infant A's hips were normal. There was no postnatal visit from the GP or any attempt by the practice to contact Child S or Adult B. The social and health indicators available to the GP should have resulted in a home visit or contact and contraceptive advice.

In August 2010 the GP examined Infant A prior to immunisation. Infant A was being bottle fed. First immunisations were given by the practice nurse. In September 2010 Infant A should have had second immunisations but Adult B brought her and there was no evidence of Child S's consent. An appointment was given for the following day and the immunisations were given when Adult B attended with written consent from Child S. In November 2010 Infant A had her third immunisation.

In [REDACTED] the practice was informed by the police that Child S's body had been found in the canal and requested her full original set of records. The records were copied and supplied to the police. There is an entry regarding a home visit by the GP, no further details are recorded. This was clarified during discussion with the GP who explained that initially he had intended to do a visit and entered it onto the computer so other members of the GP practice knew who was dealing with this tragedy. Then it was decided that it was not necessary for him to visit and it was cancelled but the entry was not deleted and that is why there is no record of the result of the visit.

A retrospective record was completed by the GP of a telephone conversation with the learning disability specialist nurse who informed the practice of a strategy meeting that had taken place on [REDACTED] about Child S who at that stage was a missing person, and that a body had been found but not identified.

### **Analysis of GP involvement**

The IMR author states that it is clear from the GP records that Child S grew up in a challenging family unit. This is particularly clear in the correspondence from the Clinical Psychologist's report, which highlights; parental relationship breakdown, poor relationship with father. The only details about Child S' father are that 'she lives with her mother and older sister', she had 'very little contact with her father' that her sister had a close relationship with her father.

[REDACTED] Mention is made of 'some contact with her grandparents' but no further details. There are also few details about her two older brothers and their relationship to Child S.

There are issues about the quality of information sent to the GP practice. The report from the clinical psychologist in 2008 mentions sexual activity in an underage vulnerable person but this is not highlighted for maximum visibility. There is reference to involvement with Project1, without any further details. No reference is made concerning Child S being given advice about sexual health or contraception. The clinical psychologist could have suggested that Adult B took Child S to her GP or to Family Planning Services and have sent this information to the GP. Child S was known to be sexually active.

The IMR author also identifies that the GP assessment sharing and recording of information is of concern. Examples of this are:

The GP entry in June 2005 on Active Summary Item Read which is Coded as 'Behavioural Problems' cross references to the detailed entry of the same date within the records 'Child S has documented emotional, violent tendencies in her childhood'. The IMR author comments that this should have raised the GP's concerns as if these tendencies were still present there would have been issue about the safety of Infant A. The GP should have ensured that all other agencies were aware of this. The only reference to Child S' history being considered in respect of her pregnancy is a comment in the GP notes in October 2009 to the midwife '*midwives – make aware patient may need additional support*'. There are no further details in the GP records about this.

The IMR author identifies issues associated with the GP practice's limited involvement with the family and a lack of leadership to develop multi agency contact to discuss the care of Child S and Infant A. After telling Child S and her mother to make a Community Midwifery appointment, the only involvement by the general practitioners is their response generated by receiving results. There is no other indication of GP involvement in Child S' care. Whilst this is common practice, in line with midwives being independent practicing professionals, it does not appear to allow for patients with other health or social problems to have their care fully anticipated. There is no indication in the GP notes of follow up of either mother or child until the 8 week assessment of Infant A. A component of maternal postnatal care is to assess Child S' emotional wellbeing which in view of Child S' immaturity and previous history is an important issue.

At no point in the GP notes is there any evidence that there was an attempt by any health discipline /agency to organise a multidisciplinary team meeting to discuss the needs of Child S when she was pregnant or after Infant A was born. This is disappointing as teenage pregnancy is well documented to be detrimental to health and wellbeing for both the mother and the child. Babies of teenage mothers have a 60% higher risk of dying in their first year and have a significantly increased risk of living in poverty, achieving less at school and being unemployed in later life (DCSF 2009).

Engaging front line practitioners in formulating a solution to critically review cases of concern would be advantageous. Therefore representatives from general practice, midwives and health visitors need to develop potential pathways to coordinate the care of vulnerable pregnant women. For example - teenage pregnancies, absent fathers, and those with safeguarding issues e.g. history of violence, drug or substance abuse. These pathways of care would need to encompass antenatal, intra-partum and postpartum care. The anticipated outcome would be that each discipline would have clear expectations of themselves and others and be able to hold one another to account. The impact would be a seamless transition of care for the newborn and beyond. Part of the pathway will be to ensure vulnerable mothers are reviewed to assess their ability to cope socially, practically and mentally post delivery. Rotherham has now established a teenage pregnancy pathway which provides clarity about the care of teenage pregnant girls.

There is also no evidence in the GP notes that Child S' capacity to consent was explored. Nor is there any evidence that sexual health or contraception was discussed or offered to Child S. An opportunity to prevent a teenage pregnancy was missed. The GP's had sufficient information on their system to highlight concerns that Child S had a learning disability and was sexually active at a young age. The GP practice was also in a position of knowing the family history and the

consequences of a teenage pregnancy. Whilst it would be extremely difficult for the GP practice to send an unsolicited letter requesting that Child S attended surgery to discuss sexual health they could, as a minimum have shared their concerns with the school nursing service. Analysing this issue it appears that the information was known in the body of Child S's records but not pulled together in an accessible manner.

The lack of postnatal contact with the GP Practice, despite entries that Child S was a young, vulnerable person with the added challenge of learning difficulties, suggests that she was lost to sight. Time wise however, this was before she gave written consent, for her mother to supervise the GP practice giving immunisations to Infant A, so does not substantiate the assumption.

Aside from the message to the midwife, about Child S needing additional support, there is no evidence in the GP notes of support from the practice to Child S or Infant A.

Good practice would be to contact the mother postnatally, to ensure there were no medical, social or psychological problems with her; and to ensure she had received contraceptive advice, also to enquire if she had any concerns about the baby to ensure that any information was acted upon by the most appropriate health professional would be to liaise directly with other involved professionals, midwives and health visitors.

The only indication in the GP notes that Adult B could be the primary carer occurs when Infant A comes for her second routine immunisations. On 16.09.2010, Infant A, accompanied by Adult B was seen in GP by a Practice Nurse for routine second vaccinations. Immunisations were declined as Adult B was not regarded as the primary carer or able to give consent until Child S provided the GP Practice with clear written instructions conferring Adult B to be able to obtain "immunisations and anything else Infant A needs at surgery when I cannot fetch her myself". After this there is only 1 contact between the surgery and Infant A, and that is after the end of the Specific Terms of Reference.

There is no evidence in the GP notes that consideration was given to ethnicity or religious issues which might arise as a consequence of Infant A being of dual heritage. There are medical and social issues that health need to consider depending upon race. Thus it is important that it is recorded as accurately as possible (Jogee 2004<sup>26</sup>). A patient's ethnicity has the potential to impact upon their health care needs (Jogee 2004). There is no evidence that consideration was given as to how the family of Infant A's father would react to being informed of having a new family member of mixed racial origin, born outside of marriage.

The IMR author also identifies that the GP does not have access to wider health information. However, the midwifery department keeps hospital notes, patient held records and increasingly data held on SystmOne. The community midwives can see all these and any information in the GP notes in the surgery, but the GP can only see the information which the Midwife records on the GP system. SystmOne Users have to get patients to agree for the information to be shared. With permission the GP practice can see all the data entered by midwives, health visitors etc but they cannot see the GP entries which makes conveying of data important. There is no information held within the GP records of health visiting and school nursing contacts with this family. Health Visitors in Rotherham do however record information on SystmOne. Good practice would have been for

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<sup>26</sup> Jogee M (2004) Religions and Cultures. A Guide to Beliefs, customs and Diversity for Health and Social Care Services. Sixth Edition [www.religionsandcultures.co.uk](http://www.religionsandcultures.co.uk)

health visitors ,midwife and GP's to discuss families of concern identifying a plan of care which clarified each practitioner's role and responsibilities.

The Community Health Services and many general practice surgeries use clinical software, SystemOne, which allows each to see the other's information. This however excludes a significant proportion of GP practices in Rotherham. To facilitate data sharing NHS Rotherham has had a policy of encouraging GPs to move their electronic clinical system to SystemOne. Unfortunately significant proportions of GPs do not find that SystemOne suits their purposes or that the conversion pathway is a smooth migration and will not change.

A long term, highly desirable solution would be to persuade the company behind SystemOne and other electronic health system companies to change their policies to one of cooperation in order to electronically share data with one another for the benefit of patient care.

NHS Rotherham and local GP Practices in recognition of the dilemma of electronic systems not having a conversation pathway are piloting, in March 2011 to May 2011, a system or read only access for GP Practices not on SystemOne. This has been trialled in TRFT Accident and Emergency Department. Therefore following post evaluation in May 2011 NHS Rotherham via the Management Executive will be in a position to make an informed decision as to whether this sharing enhances services.

An interim measure soon to be trialled within Rotherham has been to allow non SystemOne practices to access but not enter data held on SystemOne. An objection to this had been around data confidentiality. However, this is surmountable. In order to access SystemOne a personal Smart Card with a digital signature is required, thus any intrusions are recorded by an identifiable person. Any breaches of confidentiality are easily identified and rectified. A two month trial of this, by 2 GP practices, which was due to start in February 2011, now rescheduled for when the data permissions have been agreed and the smart cards authorised. Post evaluation, if beneficial, the GP Consortia should recommend an extension of this to all practices permanently.

The GP notes also had an active problem dated 18.11.2004 'Child on at risk register: Sexual and emotional abuse – siblings also registered'. This problem has not been moved to a past problem status. There are neither letters of further reviews, nor of a date as to when Infant A was removed from the register so the GP practice would not know to change the status of the problem. This is an area of significance not only for the care of Child S but for the implications for Infant A. This should have been followed up by the GP.

With the benefit of hindsight it would appear that much health data was known to front line universal health staff but multi agency health assessment fell short; this finding is similar to issues identified by the NSPCC in Ten Pitfalls and How to Avoid Them (Sept 2010). The NSPCC identified that less 'obvious' issues are insufficiently explored and that 'less obvious' signs do not stay under 'critical' review. This was a feature of this case, numerous less obvious concerns were apparent but do not appear to have been critically reviewed by the GP Practice for example learning disability, teenage sexual encounter and smoking (1.10.2008 & 4.11.2008).

## **Analysis of NHS Rotherham - General Practitioner IMR**

The IMR author has made a detailed assessment of the GP records and has discussed available material well and as specific in appropriate timings and the terms of reference are answered. The review is appropriately critical of some areas of practice and particularly in relation to a lack of information sharing and multiagency working.

### **3.5 The Rotherham NHS Foundation Trust (TRFT) – Maternity Services**

Please note that from 1<sup>st</sup> April 2011 Rotherham Community Services have integrated with The Rotherham Foundation Trust but for the purposes of this SCR they have been reviewed as separate organisations.

The IMR author reviewed Child S' contact with TRFT from 2002 but there was no record of Child S using any other services provided by The Rotherham Foundation Trust. Child S's only contact with the TRFT during the timeframe 2008 to 2010 was using maternity services provided by the TRFT. This covered a period from 10.11.2009 to 12.7.2010. After this date the care of Child S and Infant A transferred to the health visiting service.

#### **Hospital and Community Midwife antenatal care**

Child S booked her pregnancy with the community midwife at nine weeks having been referred by her GP. The Health Overview IMR identifies that she attended NHS Walk in Centre in the first instance. This demonstrated that Child S did not delay in seeking health care. Child S attended all hospital and community antenatal appointments including those with the teenage pregnancy midwife. The IMR Author states that provision of service to Child S met the National Institute of Clinical Excellence (NICE) Guidelines 2008<sup>27</sup>.

The role of the community midwife includes providing ante natal and post natal care in the community for women and their unborn infants. This includes wider public health agendas including Safeguarding Children.

The role of the teenage pregnancy midwife complements the role of the community midwife in the ante-natal period. She does not hold a specific case load but offers care within the clinic setting and is said to have good links into other services within health and education. She is based within the hospital and working with the community midwifery team provides continuity of care identified to be essential in the engagement of this age group. (NICE 2010)

The role of the hospital midwife was to provide care whilst Child S was in hospital. Child S had involvement with labour ward midwives during labour and maternity ward midwives on the post natal ward. They too are expected to fulfil their roles and responsibilities as regards safeguarding outlined in Section 2.96 'Working Together to Safeguard Children' 2010<sup>28</sup>.

The teenage pregnancy midwife identified safeguarding issues in relation to the fact that Child S:-

- Had learning difficulties
- Was young at the point of conception
- Had been subject to a child protection plan

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<sup>27</sup> Antenatal care : Routine care for the healthy pregnant woman . NICE 2008

<sup>28</sup> Working together to safeguard children a guide to interagency working to safeguard and promote the welfare of children DCSF 2010

[REDACTED]

- Did not disclose the identity of the baby's father except [REDACTED]

Child S's pregnancy progressed normally and she received the investigations and pattern of care outlined in NICE guidelines 2008<sup>29</sup>. Child S was said to be positive about the baby and preparing the equipment required for its care. There were no obstetric concerns noted. The teenage pregnancy midwife provided additional support and information.

When Child S was 34 weeks pregnant a birth plan was completed by Child S with teenage pregnancy midwife in which she identified Adult B and her aunt as her birth partners. It is not known if the aunt was Child S' aunt or Sibling 3. The IMR author identifies that what is clear from the records is that the teenage pregnancy midwife considered that Child S felt Adult B to be supportive and helping Child S to prepare for the baby.

There does not appear to have been an appreciation of the impact of Child S' learning difficulties on her ability to parent effectively. This may have resulted from Child S's ability to conceal her level of difficulty in reading and writing and also that the national maternity records do not ask for an assessment of capacity. It is clear to the IMR author in reading the records and talking with key staff that they were not aware of the level of Child S' ability and therefore did not plan to address it. Giving out the information leaflets usually supplied to women antenatally and postnatally would not have been beneficial to a girl who could not read. This not only increased the risk for Child S but also for Infant A. Some concerns may have been alleviated by Child S' agreement to stay in hospital for 5 days after the birth of Infant A which would have provided an opportunity for further assessment.

The teenage pregnancy midwife was contacted by Centre1 to inform her of their concerns about Child S. There is a difference between the two IMRs about the content of the interaction between teenage pregnancy midwife and Centre1. Centre1 state that they contacted teenage pregnancy midwife to express their concerns about Child S's ability to cope and to ensure that she was engaging with health services.

There is evidence to show that Child S was committed to the pregnancy - she:

- Did not have a termination of pregnancy
- Kept and brought with her to appointments her antenatal records
- Sought appropriate advice when she was concerned that the baby was not moving and attended TRFT as advised.
- She attended promptly at 40 weeks when she was in spontaneous labour.
- She did miss 3 antenatal appointments but these were speedily followed up. There is no indication in the midwives or GP records why she missed the appointments.

The IMR author notes that at the time of delivery of Infant A, all the required midwifery and medical care required was provided and the documentation completed. Child S was unable to have a

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<sup>29</sup> Intrapartum care: care of healthy women and their babies during childbirth. NHS Guidelines 2008

normal delivery as Infant A's heart rate dropped, so a forceps delivery was required. Infant A was in good condition at birth and there were no concerns about the baby's condition.

Child S decided that she did not want to stay in hospital for 5 days and decided to leave hospital the day after the birth of Infant A. Unsuccessful attempts to encourage her to stay were made but she wanted to go home. The midwife liaised with social care and was informed by the social worker that the pre birth assessment was positive and there were no concerns about Child S taking Infant A home with Adult B. The midwives were not aware of any social or medical reasons to necessitate her staying so discharge arrangements were made and she left.

The staff completed the required discharge arrangements which included an explanation about why Child S had required a forceps delivery, discussions about Infant A having a 'clicky hip' and the required follow up. Routine advice about child care and contraception was given. Leaflets were provided to support this advice which would not have been read by Child S.

### **Community Midwife**

Child S and Infant A were seen on their first day at home by the Community Midwife. The Social Worker had also visited and Child S informed the Midwife that the Social Worker would not be visiting again. The community midwife made 6 further visits during which the health of Child S and Infant A was assessed and smoking cessation was discussed. Contact ended on 12.7.2010 when care of Child S and Infant A transferred to the health visitor.

### **Training**

The teenage pregnancy midwife confirmed that she has completed Level 3 training in 2010. Level 3 is the accepted level aimed at those members of staff who have significant dealings with children and young people. The focus is on multi-agency work. This includes issues around pregnancy. The teenage pregnancy midwife has supervision from her Supervisor of Midwives and safeguarding supervision from the Safeguarding Team at The Rotherham NHS Foundation Trust. This is in line with the Supervision of Midwives Policy.

The community midwife and HMW1 also confirmed their completion of Level 3 training during 2010. HMW1 also completed 'Child Protection in Practice' module at the University of Sheffield which is at degree level.

Community and ward midwifery staff have access to the Safeguarding Unit at The Rotherham NHS Foundation Trust for supervision on specific cases, but does not hold caseloads. HMW1 had informed NMWS1 regarding Child S post delivery and had sought advice appropriately as to the discussion regarding the Centre1.

All midwives are expected to complete level 3 of TRFT Safeguarding Children training which is in line with Working Together Group 3 training; this highlights the importance of inter-agency working. All the midwives who gave Child S and Infant A care have accessed this.

## Analysis of Involvement

The Care Quality Commission reviews the performance of midwifery services in NHS Trusts which are then placed into four categories - least well performing, fair performing, better performing and best performing. These categories only show how hospitals perform relative to each other; they do not show absolute levels of quality of care. The Rotherham Foundation Trust was awarded better performing.

The policy context which should have influenced and guided change in the development of local health services for teenage girls is;

- National Service Framework for Children, Young People and Maternity Services 2004<sup>30</sup>
- NICE guidance on antenatal or postnatal care 2006 and 2008.
- The Government in 2007<sup>31</sup> also launched Maternity Matters which sets the context and vision for maternity care.
- Teenage Pregnancy Strategy for England<sup>32</sup>(1999) to address both the prevention of teenage pregnancy and the support needs of young parents.
- Numerous reports, toolkits and supportive guidance to help Hospitals meet the needs of teenage mothers and to assess their performance.
- Common Assessment Framework (DfES 2006) alongside other key documents.

In 1999/2000 Rotherham developed a teenage pregnancy strategy in response to the national strategy and as a result of the high rates of teenage pregnancy in Rotherham.

There have also been changes in relation to:

- Undergraduate and postgraduate training programmes to address the needs of teenage pregnant young women and the inclusion of partners in their care are also well established.
- There is a specialist teenage pregnancy midwife who has helped to raise the profile of teenage pregnancy.
- It is not routine for all teenage pregnant young women to have a Common Assessment Framework completed.
- Community midwives work in co-located teams in children's centres.

The IMR author identifies a number of significant issues about the care of Child S during her pregnancy and when she gave birth to Infant A. Firstly that the clinical care given to Child S and Infant A reflects that expected in NICE Guidelines 2008 and NSF 2004. The care given is well documented in line with information governance requirements. The chronology is stated by the IMR author to demonstrate that routine appointments with both the community midwife and hospital appointments were provided appropriately for Child S' health needs

The areas where the service could have been improved relates mainly to:

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<sup>30</sup> National Service Framework for Children, Young People and Maternity Services DoH 2004

<sup>31</sup> Maternity Matters: Choice, access and continuity of care in a safe service. DoH 2007

<sup>32</sup> Social Exclusion Unit. Teenage pregnancy. London: HMSO, 1999

- Risk assessment
- Providing Child S focused care
- Multi agency working

## **Risk Assessment**

The IMR author identifies that the care of Child S may have been influenced by a lack of effective clinical risk assessment and a resultant plan of health care to meet the identified needs of Child S who was young, had a learning difficulty, was a single parent and had a history of being involved with social care with regard to inappropriate sexual boundaries.

A risk assessment forms the framework for identifying the care that is required and the agencies best placed to deliver it and also the means to evaluate the outcome of input and to re-evaluate the effectiveness of services. The fact that this was not completed did influence the care she received. The fact that other agencies who had involvement with Child S and Adult B and were aware of her pregnancy had not completed a risk assessment did not assist TRFT to plan the care of Child S to meet her and Infant A's needs.

Information provided by Child S at booking with the teenage pregnancy midwife should have resulted in the completion of a Common Assessment Framework which would have been an appropriate tool to explore if Child S required services in her own right without waiting for the viability of her pregnancy. The IMR author states that although some issues of vulnerability were identified, the teenage pregnancy midwife did not consider Child S to be at risk of immediate harm or that her learning disability precluded Child S from retaining information. The learning disability diagnosis was offered by Child S herself in line with booking information, but the teenage pregnancy midwife did not consider it was apparent in conversation with her. This may reflect the fact that Child S was skilled at hiding the impact of her learning disability on her everyday life.

The fact of knowing that Child S had learning difficulties should have been explored further in terms of her care with an up-to-date assessment of learning difficulties and obtaining more explicit knowledge around her learning difficulty from community health services. The timing of Child S' death coincided with SystmOne being available on a 'read only' basis within pilot areas in the hospital including midwifery. This should be viewed as a pro-active move by TRFT and Rotherham Community Health Services to provide a seamless service in the light of the anticipated integration of services in April 2011.

The teenage pregnancy midwife did not have the details of Child S so she contacted social care and was told a pre-birth assessment was taking place. The teenage pregnancy midwife was also contacted by Centre1 who had concerns about Child S. These were said to be focused on non-attendance to their service. The teenage pregnancy midwife did not share the level of concerns and advised them to contact Social Care directly.

The teenage pregnancy midwife could have gained more information as part of a risk assessment by the involvement of the liaison paediatric specialist nurse who had access at that time to SystmOne which would have provided more detailed information about Child S. This information would have clarified Child S' involvement with learning disability services and issues associated with her previous educational statement of needs, in order to plan which health promotion and interventions were required to be appropriate to Child S level of understanding as Child S was very



was not a qualified social worker. She did not feel however that it was unsafe to discharge Child S and Infant A as the parenting observation in the obstetric records documents good care to Infant A and that Child S and Infant A would be residing at Adult B's home.

### **Communicating with Child S**

The IMR author identifies that it is apparent that Child S' mother, Adult B was present at many professional contacts, which made it difficult to visualise Child S in the records and hear her voice as a child in her own right and what her true perceptions and opinions on major issues were. This is also reflected in the GP records. This reflects the fact that it would appear that Child S was not seen as a child. The teenage pregnancy midwife did not make a child inquiry about Child S as a child but for the protection of Infant A.

Understanding Child S's parenting history would enable professionals to have a clearer understanding of what might influence her ability and approach to parenting and model new ways of responding to and caring for infants and toddlers accurately assess the strengths and address difficulties in interactions between her and her baby.

[REDACTED]

It was of note that Child S would not stop in hospital longer with Infant A as she had originally agreed to do in the birth plan completed with the teenage pregnancy midwife. It is unclear whether Adult B had influence on this decision. The IMR Author acknowledges that the reasons for teenage pregnancies vary, but that adolescence is a tumultuous time and inevitably involves regressive behaviour which must be considered in planning their care. Problems can be more pronounced if the relationship between the teenager and her own mother has failed to establish a secure basis for managing the complex tasks required of these transitional years (Waddell 2009<sup>34</sup>) This would be of greater significance because of Child S had learning difficulties and that Adult B was considered to have difficulty providing emotional support to Child S. This information was not known to the teenage pregnancy midwife.

Appointments with the community midwives and the teenage pregnancy midwife were generally kept appropriately and there were no concerns documented about Child S' attitude to her pregnancy or any health needs identified other than advice to take oral iron tablets when Child S' iron count was found to be on the lower parameters of optimum levels for health.

Child S booked for ante natal care at nine weeks of gestation (this is 10 weeks in the GP record). This is an indication of engagement with midwifery services and is often a marker that the mother is positive about the pregnancy. Booking for care at that time means that an expectant mother is able to benefit from a range of routine screening for obstetric risks including tests for anaemia, rubella status checked, testing for syphilis, testing for HIV. It is also positive that Child S brought

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<sup>34</sup> Waddell, M. (Dec 2009) Why Teenagers Have Babies. *Infant Observation*. Vol 12, 99 271-281.

her hand held records to all her ante-natal appointments. Hand held maternity records mean that all information about the pregnancy is in the woman's care. This serves to give her ownership and means that if advice is sought in another area, then all important aspects of care are readily available. She was not able to read them.

No further reference is made during the pregnancy of the birth father to Infant A or Child S's perception of any intended involvement following delivery.

[REDACTED]. Infant A would be dual heritage, and there are no entries in the documentation as regards Child S's perception of this, how Infant A's identity needs would be addressed and if indeed Child S or Adult B considered this to be significant. This was a missed opportunity and should have been considered in relation to the safety and welfare of both Child S and Infant A. There was obviously no consideration of the issue of sexual exploitation or sexual abuse. Child S was a vulnerable underage child.

Maternity Services were aware of social care completing a pre-birth assessment in relation to Child S and unborn Infant A of which the concerns highlighted would be addressed, including learning difficulties.

Leaflets and advice were given as part of transfer protocol, including safe sleeping and feeding information. In addition a feeding demonstration was completed with Child S prior to discharge. It is documented that Adult B was present at that time. Child S would not have been able to read the leaflets and to assimilate the range of information made available. She had informed them of her learning difficulty and the midwives should have established her level of ability. However, Child S did not give any indication that she was not able to read.

### **Multi Agency Working**

There is lack of inter-agency communication as the outcome of the pre birth assessment by social care was not shared with midwifery staff and ward staff had to contact social care to clarify issues pertaining to a safe discharge. SW1 was clear in conversation to HMW1 that her assessment concluded that Child S had an extremely supportive home environment and that Child S would be able to parent Infant A with the help of Adult B. This created false security as a pre birth assessment was not completed. HMW1 did ask that the pre birth assessment be faxed over to TRFT but this is not evidenced in the obstetric records. As part of the birth plan compiled with teenage pregnancy midwife, Child S had agreed to stay for five days in hospital post delivery. However, she did not wish to stay following delivery and voiced her wish to be discharged. HMW1 was not aware that the member of staff from Social Care was not a qualified Social Worker. HMW1 had built a good rapport with Child S. During the course of conversation on post natal day 1, Child S did disclose who the father of the baby was. This information was not shared with CSCS to establish if there were any concerns about him.

[REDACTED]

Adult B was present for the birth of Infant A and for extended periods on the postnatal wards. She was present during the conversations when ward staff were trying to persuade Child S to stay longer in order to recover from labour and to take advantage of guidance and support from staff taking into account the she was young and had a learning disability. During this period staff would also have had the opportunity to observe Child S's own parenting capacity and any concerns which required further consideration in terms of risks and needs. This forms part of TRFT Safeguarding

Children Package which complements National Maternity Records and uses the domains of the 'Assessment Framework' to detail both strengths and weaknesses around infant care. One of the domains of the framework is parenting capacity. This is a development from a previous Serious Case Review recommendation within TRFT and clearly identifies any parenting concerns in the maternity records. It also provides an opportunity for staff to highlight positive care and interaction noted. A recent audit of the Safeguarding Pack suggests that staff are becoming familiar with its usage and allows information to be viewed and analysed in a concise manner. On discharge from hospital, a copy is put in the baby's notes so that on any future admissions, pertinent information would be available.

It was unfortunate that Child S and Infant A left the ward prior to the staff being able to organise a discharge planning meeting, despite HMW1 trying to persuade her to remain. It would be good practice to hold a discharge planning meeting before transfer into the community. There is a Discharge Planning Protocol in place at TRFT, but in this particular case there were no Plans of Protection around Child S and Infant A, which means it is a process which cannot be enforced, only encouraged.

[REDACTED]

[REDACTED]

During the short hospital stay there are no difficulties noted in terms of Child S' care of Infant A or of her own post natal health. This includes emotional health and mood of Child S.

It is noted that on the new born infant check, Infant A had a 'clicky' hip. This is not an unusual finding of post natal examinations. As advocated by post natal guidance (NICE 2006<sup>35</sup>), the protocol recommends a follow up ultrasound examination of the hips at six weeks of age to exclude congenital dislocation of the hips, this was noted in the hospital copy of the results from the parent held records. It is noted that as a point of good practice, the HMW1 looking after Child S liaised the discharge out to the CMW1, HV1 and SW1 and informed them of Child S and the current situation. Unless there are concerns it is standard practice on the post natal ward that the ward clerk informs the community midwife who will visit the home on the following day for post natal checks on mother and infant.

Community Midwives visited more frequently than is now recommended by NICE guidance having commenced their involvement postnatally on discharge 24.06.10 until handover to the Health Visiting Service. Community Midwifery Service did so in the context of Child S being young and having learning difficulties (NICE guidelines for post natal care 2006). It is detailed in the chronology that during this period of community midwifery involvement, SW1 had visited and informed Child S that she did not need to visit again. This information was given to the midwife by Child S. There is no documented liaison between midwifery services and social care regarding this decision. No concerns regarding Child S or Infant A are documented in the post natal records including physical and emotional well being.

One of the fundamental factors in the care of Child S was the ability of the midwives and GP to form an assessment of Child S and the risk she presented for her unborn baby and then to Infant A. The IMR author identifies the difficulties of the hospital staff gaining information from social care

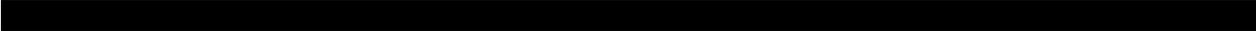
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<sup>35</sup> Postnatal care: Routine postnatal care of women and their babies. NICE 2006

to enable an effective care plan to be established. There was enough information to complete a Common Assessment Framework (CAF) which would have provided a framework for an assessment which should have resulted in a strategy or planning meeting to develop a multiagency approach to Child S's care. It was not routine practice at this time to undertake either a pre CAF or full CAF. The new teenage pathway launched in November 2010 stipulates that a pre CAF will be completed on under 19 year old women and a full CAF on all girls 16 and under.

As the Teenage Pregnancy Midwife service is limited to two days it is important that the midwifery service as a whole has a good understanding of the issues of teenage pregnancy and the potential vulnerability of the girls/women.

As the overview author reading the IMR it is not clear that there is an understanding of the emotional capacity and needs of vulnerable teenage mothers particularly when they are as vulnerable as Child S. CSCS and Project1 were aware that Child S was pregnant and had a responsibility to ensure that the health services were fully briefed to enable them to make the required risk assessment. If the risk to Child S and Infant A had been acknowledged from the information available to the service it would have provided an opportunity to establish a strategy meeting to identify the issues and to discuss future management. The indicators of sexual exploitation and /or abuse or the implications surrounding Infant A's father did not lead to any uncertainty about Child S's level of vulnerability.


### **Analysis of the The Rotherham Foundation Trust IMR**

The IMR author has analysed available material well and as specific about appropriate timings and the terms of reference are answered. The IMR author has used the available information to analyse information effectively. The review is appropriately critical of some areas of practice particularly in relation to the multiagency working. The recommendations reflect key issues.

### **3.6 NHS Rotherham- Rotherham Community Health Services**

Please note that from 1<sup>st</sup> April 2011 Rotherham Community Services have integrated with The Rotherham Foundation Trust but for the purposes of this SCR they have been reviewed as separate organisations

The IMR author provides an analysis of the services involved with Child S between 2008 and 2010 which included:

- School Nursing Service
- Learning Disability Services
- Community Paediatric Services
- Community Dental Services
- Safeguarding Children Health Team
- Health Visiting Service

And with Infant A

- Health Visiting Service

#### **School Nursing Service**

The School Nursing Service became involved with Child S at the point of her entry to School2 in 2002. The major face to face contact made with Child S related to an annual hearing check as a result of a family history of progressive deafness. This was completed and Adult B kept fully informed of the outcome.

The school nurse also attended a strategy meeting to discuss Child S' behavioural problems in 2003. This is recorded without detail to have resulted in a multi agency package being established.

SN1 attended a Child Protection Conference in November 2004 to discuss concerns related to [REDACTED] and the implications for Child S. SN1 provided a brief report about Child S. The report did not provide an historical context of preschool health visiting involvement or an analysis of Child S's health needs or outstanding immunisations.

Concerns about Child S resulted in a Child Protection Plan being agreed for Child S. SN1 then attended the entire core group meetings appropriately and had monthly contact with Child S until 2005. In February 2005 the core group meeting decided to end Child S' Child Protection Plan and then SN1 attended Child in Need meetings. The Child Protection Conference made no specific recommendations for the SN1 involvement. The focus of the school nursing service was on Child S' growth which was consistent and within expectation. SN1 always found Child S to be talkative, clean and appropriately dressed. There were issues related to outstanding immunisations which SN1 sought to address by encouraging Adult B to take Child S to their GP to complete. Child S also needed dental care and Adult B was encouraged to take her to the school dental service.

There is no evidence of any face to face meeting between Child S and SN1 from February 2005 until SN1 handed Child S to SN2 in December 2006. There were however observational entries from SN1 concerning Child S's behavioural pattern reflecting what was happening at home.

[REDACTED]  
[REDACTED]  
[REDACTED] Between February 2005 and December 2006 SN1 worked with Project1 , social care and education services in action planning to safeguard Child S. SN1 reports that at school meetings Child S's behaviour was getting more difficult to control and that her engagement with Project1 was erratic.

SN2 became involved with Child S again in December 2006 and whilst she had no face to face contact with Child S she continued to attend the multi agency meetings. The records show an increasing concern about Child S. The IMR author lists the concerns as being:

- Child S living in overcrowded house in 2007
- Child S school absence rate
- Her verbal and physical abuse at home
- Allegedly being involved with an Asian shopkeeper
- Her behaviour at school.

The historical information shows a high level of involvement by the School Nursing Service in 2007 however there is no evidence of contact being made with Child S by the Service in 2008. The chronology shows there was one contact in 2009 by a school nurse support worker, when she assisted the Clinical Medical Officer during a routine medical review when Child S was 15 years old.

The Medical identified issues in relation to:

- Weight and the need for healthy eating and exercise.
- A lack of attendance at Dental Services.
- Child S smoking 10-20 cigarettes per day.
- Child S being under the care of a Clinical Psychologist.

A referral was made by CMO1 to Dental Services and a growth review was recommended. There is no evidence that SNSW1 informed the Named School Nurse of the outcome of the medical. This would have been good practice. It is acknowledged that the school nurse would have had access to the record. CMO1 forwarded leaflet information to support the advice given around healthy eating and exercise. Child S did not attend the offered dental appointment and did not attend for her growth follow up.

A strategy meeting was convened in April 2010 due to concerns that Child S was involved in sexual exploitation. SN3 was nominated to represent the School Nursing Service at meetings in relation to Operation Czar, the co-ordinated multiagency approach to concerns in relation to the organised sexual exploitation of a group of girls. Information was shared that Child S (aged 16) was pregnant and had learning difficulties. The plan agreed at the meeting as recorded by SNS1, stated that a pre-birth Conference was to be held. There was no further involvement by the School Nursing Service as Child S was no longer within Universal Services as she had left school.

## Analysis of School Nursing involvement

The IMR author correctly identifies that the school nursing service fulfilled its responsibilities in relation to the screening of Child S' physical development particularly hearing screening. There were difficulties getting Adult B to take Child S for immunisations and to dental services but the school nurses kept an ongoing dialogue with her to try to encourage her. Discussions with the GP practice might have added additional support.

Records show SN1 and SN2 engaged diligently in multi agency working and meetings, initially with Child Protection Planning followed by Children In Need and latterly multi agency meetings. Like other agencies their input to working with Child S must have been influenced by the lack of a coordinated plan of care for Child S.

The IMR author notes that there were some issues in relation to record keeping as school nurses met procedural requirements by producing a report but that it did not meet the expected South Yorkshire Area Child Protection Committees Child Protection Procedures in 2004 to 2008. The role of the school nurses is identified by the IMR author as appearing to be ill defined in relation to the planning process. There is no action plan recorded which makes it difficult to determine what the role of the school nurse was and if they were achieving that role as part of a child protection plan and to provide informed input into the child in need meetings.

During this period there is an apparent lack of contact with Child S to reassess her needs. The contribution was based on the health needs identified in 2004 with no up to date assessment evident. This included Child S' view of her own health and well-being. The success and direction of the Multi Agency Working appears to have been limited, as Child S continued to exhibit concerning behaviour over a 5 year period with little change being effected.

Child S was identified as having a number of health issues in 2009 that may have benefited from support from the School Nursing Service.

Child S was assessed by the CMO as being overweight. Long-term health consequences associated with being overweight can be influenced by health eating and exercise. There is evidence that the CMO forwarded healthy eating and exercise leaflets. These leaflets were possibly only of benefit to Adult B as Child S was unable to read. There is no evidence to show that a follow up of Child S' growth was undertaken.

Although a referral was made to Dental Services - Child S did not attend appointments.

Child S smoked 10-20 cigarettes per day at the age of 15 years. The short and long-term health consequences of smoking can be influenced by smoking cessation support. There is no evidence of a referral being made to the Specialist Smoking Cessation Service as a result of any discussion. In view of Child S's history of being at risk of sexual exploitation, some discussion in relation to smoking may have raised questions and any anomalies about the financing of the habit.

CMO1 did have access to all the historical information in relation to Child S and therefore to the Child Protection Conference minutes. Sexual health was not a feature of the medical which is surprising given the information available.

SNS1 attended a strategy meeting in April 2010 when Child S was no longer in receipt of Universal Services and therefore not covered by the School Nursing Service. Issues arising from the meeting included Child S being pregnant at 16-years of age, Child S having a learning difficulty, and her possible links to sexual exploitation.

Good practice by SNS1 would have produced the following:

- Interdisciplinary communication
- Information being provided to the Health Visiting Service to ensure a lead health professional from NHS Rotherham Community Health Services became involved in the planning processes now Child S was pregnant. This information would also have been useful to inform the health visiting antenatal contact expected as part of the Child Health Promotion Programme.
- Also information for Midwifery Services to ensure they were aware of the risk in relation to sexual exploitation and of Child S' learning difficulty. The contact made by a Midwife with the Health Visiting Services on the 23<sup>rd</sup> June 2010 suggests the Midwifery Service was aware of both issues, but SNS1 was not aware of this at the time.
- Information being provided to the Child Protection Health Team at Rotherham NHS Foundation Trust to ensure they were aware of both the risk of sexual exploitation to Child S and of her learning difficulty.
- When considering multiagency working, there was a need for a co-ordinated plan around Child S and therefore ongoing dialogue between Health professionals and Social Care was required.

### **Learning Disability Services**

The Learning Disability Services became involved with Child S in January 2007 following referral from SN1 in October 2006. The contact with Child S ended in January 2009 because of Child S's non attendance.

The IMR author makes reference to the fact that the waiting list for direct intervention with young people was lengthy at that time as there was a lack of clinical psychologists. It took until January 2008 before Child S was seen for the initial assessment by the clinical psychologist. This was 16 months after the initial referral.

During this period LDW1 and LDW2 attended the children in need meetings to liaise with professionals working with Child S, to inform assessment of Child S by gaining insight into the issues impacting on her and to provide in direct advice.

LDW1 and LDW2 recorded that they saw Child S as a young person who was:

- Difficult to engage
- Running away from school and damaging property
- Considered to be sexually vulnerable
- Verbally abusive.
- Inciting the school to suspend her
- Difficult for Adult B to set boundaries and establish appropriate reward systems.
- Assaulted a pupil in school which necessitated police involvement

In November 2007 Adult B met with CP1. She informed CP1 that Child S:

- was verbally and physically aggressive to teachers and pupils
- verbally abused strangers
- was not able to read and write
- had a poor concentration span and memory

- had no concept of dangers to herself or the consequences of her behaviour.

The assessment of Child S commenced in January 2008. She is said to have engaged well at the meeting with the clinical psychologist. She identified that she liked her mother and a special friend

Following this appointment Child S refused to speak to CP1 at the next two appointments. In February 2008 CP1 contacted the school and was informed that Child S was disengaging with Project1. They were concerned that she was displaying sexualised behaviours towards boys who 'dressed cool' and did not look as if they had learning difficulties.

At the next meeting Child S engaged well with CP1 and spoke about wanting to be a cleaner in a large hotel. In March 2008 Child S was assessed to have a low self esteem and an inability to identify positive things in her life. It was agreed to undertake work on self esteem, anger management and possibly family therapy.

Child S then defaulted two appointments and refused to cooperate at two further appointments. During this period CP1 continued to work with Adult B, The sessions were to focus on managing Child S' behaviour through the use of reward systems. Adult B however stopped attending in July 2008 and so the anger management work was never commenced.

The assessment identified that Child S had had been exposed to

This it was identified had led her to exhibit violent behaviour, risk taking behaviour and poor engagement with school, combined with her low self-esteem and her learning difficulty. The clinical psychologist felt Child S had become a very vulnerable young woman.

The issues for Child S at this time included:

- Very low self-esteem
- Issues with anger management
- Disengagement with appropriate therapeutic services
- 
- 
- Learning difficulty
- Risk taking behaviour
- Aggressive outbursts
- Disengagement with school.

The IMR author identifies that in October 2008 two further appointments were sent to Adult B. This was to work on managing Child S's behaviour. The first of these was cancelled and the second defaulted. A letter was sent to Adult B in November to ask her to make contact to agree a further appointment in order to discuss future involvement with the service. There was no further contact and Child S was discharged from the service in January 2009. A concluding report was produced by CP1 identifying Child S's behavioural problems and CP1's opinion of the key issues influencing them (identified

above).

The report was copied to the school, the college and Child S's GP.

### **Analysis of Involvement of Learning Disability Services.**

The learning disability services were involved with Child S and Adult B for 18 months from January 2007 to July 2008. There was a delay of 16 months from the point of referral until Child S had her first meeting with CP1.

Research identifies that long waiting lists and failure to attend appointments are a common problem in child and adolescent psychology and psychiatry. Long waiting time has also been found to increase the rate of non-attendance (Subotski & Berelowitz, 1990).<sup>36</sup> Jones & Bhadrinath (1998)<sup>37</sup> found that general practitioners' (GPs') main concern regarding prioritisation of child behavioural problems was the time taken for referrals to be seen.

During the period of referral to the point of Child S seeing CP1, LDW1 and LDW2 attended the children in need meetings. This at least enabled a more expert contribution to the CPCs and Children in Need meetings and enabled Child S' assessment to be informed by contact with Adult B and with information to add to her assessment.

It is difficult to identify from the IMR if there were any other initiatives to decrease waiting time to first appointment and improve attendance at child clinics but the timescales were not satisfactory. The IMR author identifies that that funding has subsequently been obtained to increase the Psychology Service and this has now reduced waiting times to 13 weeks.

Child S was 15 years old at her discharge from the Learning Disability Service. There is no evidence of any communication with the school nurse or of a copy of the final report being forwarded to her. At that time guidance was available as part of Child Health Promotion Programme which included information about defaulted appointments but it only applied to universal and not specialist services. Therefore it would not have been expected to have been used by Learning Disability Services. There is now new more detailed guidance which was launched in February 2010 which is applied to all services.<sup>38</sup> The IMR author identifies that referral to CSCS as a Child in Need would have been appropriate as CP1 stated that Child S was a very vulnerable young woman. The records suggest that Social Care ceased their involvement when the Learning Disability Service commenced their sessions.

The IMR author identifies that whilst Child S' case was open during September 2008 to January 2009 there was no direct contact with the service or individual appointments made. The decision had been made to work with Adult B to raise her skills to be able to handle Child S's behavioural problems.

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<sup>36</sup> Subotski, f. & Berelowitz, m. (1990) Consumer views at a child guidance clinic. *Newsletter of Association for Child Psychology and Psychiatry*, **12**, 8-12

<sup>37</sup> Jones, s. m. & Bhadrinath, B. R. (1998) GPs' views on prioritisation of child and adolescent mental health problems. *Psychiatric Bulletin*, **22**, 484-486.

<sup>38</sup> Practice Guidance on the Refusal or Withdrawal from Child Health services. Feb 2010

The summary report is said to be comprehensive and reflected the key areas identified in Child S's case notes. The report was copied to the school, the college and Child S' GP but not to the school nurse who made the original referral.

### **Community Paediatric Services**

In January 2009 Child S was selected as a school leaver for a final medical review due to her having a statement of Special Educational Need. She attended with Adult B. Adult B stated that she did not have any concerns about Child S apart from behavioural issues which were said by Adult B to happen when she did not get her own way.

CMO3 was obviously aware of the involvement of the Learning Disability Service and was informed by Adult B that they had an open appointment. CMO3 was aware that Child S was not attending school and the IMR author identifies that there was reference to

The result of the medical was that concern was expressed by CMO 3 regarding Child S's being overweight, smoking and lack of dental care. Immunisations are recorded as up to date when they were not. CMO3 made a referral to Community Dental Services and sent leaflets to Adult B regarding healthy eating and details of local exercise classes. CMO3 was to follow up this appointment to examine if Child S had lost weight but this appointment was defaulted. There is no evidence of discussions about contraception or sexual health.

### **Analysis of Community Paediatric Services**

CMO3 had in the records available both the school nurse records and the Child Protection Conference minutes, so the history of Child S being at risk of sexual exploitation was therefore available. CMO3 missed an opportunity to discuss sexual health issues and also the opportunity to discuss smoking cessation was missed and therefore referral to appropriate services to help Child S was not made.

### **Community Dental Services**

Child S was referred to the Community Dental Service in February 2009 as Adult B could not register with a local dentist. CMO3 provided brief details about her learning difficulties and the fact that she was overweight. The appointment was defaulted and Child S discharged from the service. There is no evidence that CMO3 was notified that Child S had failed to attend the appointment.

### **Analysis of Community Dental Services**

To give Child S one chance to attend an appointment is an extremely limited service. The IMR author highlights that again there is no evidence that the person who made the original referral was notified that either Child S had defaulted her appointment and that she had been discharged from the service.

## Health Visiting Service

The IMR author identifies that the health visiting service had limited involvement with Child S and Infant A. HV1 became involved with Child S following the birth of her daughter, Infant A, on the 23<sup>rd</sup> June 2010. HV1 had been given background information by a Midwife which detailed:

- Possible sexual exploitation, previous Child Protection Planning
- [REDACTED]
- [REDACTED]
- Current concern in relation to Child S's ability to retain information.

The health visiting service did not undertake an antenatal visit because there was no notification of Child S' pregnancy made to the health visiting service. HV2 prior to seeing Child S searched available sources of information to gain background details to support her direct contacts, on the 6<sup>th</sup> and 7<sup>th</sup> July 2010 at home and on the 19<sup>th</sup> August 2010 at the Well Baby Clinic. Child S was seen on the three occasions by Health Visiting Services. Further home visits were carried out on the 27<sup>th</sup> July 2010, 16<sup>th</sup> September 2010 and the 1<sup>st</sup> October 2010, but Child S was not seen as she was reported to be ill or at College. There were 3 no access visits by the Service, on the 21<sup>st</sup> July, 23<sup>rd</sup> July and the 8<sup>th</sup> September 2010, the first two of these no access visits being opportunistic and the third being an appointed contact.

HV2 reported that Child S attended the well baby clinic on the 19<sup>th</sup> August 2010 with Infant A and was recorded to have been subdued and in need of prompting to undress Infant A. Although attempts were made to follow this up and to assess her overall well-being, Child S was not seen again by the service after this date.

## Analysis of Health Visiting Service

The Child Health Promotion Programme requires that the health visiting service undertakes an antenatal contact to all first time parents but as identified above there was no notification made about Child S being pregnant. Therefore contact was not established by the health visitor with Child S until October 2010, after the birth of Infant A.

The health visiting service had three face-to-face contacts with Child S following the birth of Infant A. The IMR author states that the level of contact afforded to Child S was appropriate. It is difficult to assess if this was the case as Child S was not seen until 19<sup>th</sup> August and on that occasion it was noted that she was subdued. The assessment of family circumstance and parenting capacity is an ongoing process. HV2 gathered extensive information to inform her visiting and with Infant A being [REDACTED] when Child S died, HV2's assessment was still in the early stages.

The limited contact with Child S made it difficult for any level of assessment to occur around her physical and emotional health, her adaptation to parenthood as a 16-year old with her own difficulties, and her understanding of the physical, emotional and developmental needs of a baby. It is recorded that Child S wanted to raise Infant A as a Muslim and had had Infant A's head shaven, in keeping with Asian culture. HV2 stated at interview that she had not had the opportunity to gain any insight into Child S's understanding of the culture and how the putative father might respond on approach by Child S for support. Both were areas HV2 had hoped to assess.

## Health visiting involvement with Infant A

The Child Health Promotion Programme requires that the health visiting service undertakes a new birth visit between the 10<sup>th</sup> and 14<sup>th</sup> day post delivery. This was achieved, with Infant A, first being seen on the 6<sup>th</sup> July 2010 at the age of 13-days. A high level of detail is provided in the record from this contact.

The health visiting service had a total of six contacts with Infant A between her birth [REDACTED]. Four of the contacts were home visits and occurred when Infant A was 13-days old, 14-days old, 5 weeks of age and 14-weeks of age and the remaining two were clinic contacts. Three opportunistic visits were attempted but were unsuccessful. Infant A was seen at 8-weeks and at 12-weeks of age at the well baby clinic. This level of contact is above that expected by the Child Health Promotion Programme.

The ongoing assessment of Infant A by health visiting services included growth, feeding patterns, and developmental progression. Growth monitoring was achieved by both home contacts and clinic attendance and showed Infant A to have gained weight at a consistent rate.

Infant A's feeding patterns were initially assessed as appropriate with her being bottle fed on first stage milk. By eight weeks of age Infant A had been changed to second stage milk the reported reason being due to her being unsettled and by 12 weeks, weaning had commenced with the introduction of baby rice. The Department of Health Guidelines recommend that healthy term infants do not require any additional nutrition to either breast milk or formula milk until 6 months (26-weeks) of age. These recommendations were discussed with Adult B when Infant A was 12 weeks of age. However, by the time Infant A was 14 weeks of old, mixed feeding had increased to two meals per day.

The Child Health Promotion Programme offers a routine contact when a baby is between two and four months to provide guidance around the introduction of solids and the recommended time for this. Unfortunately the family missed this appointment which had been offered [REDACTED]

Infant A's developmental progression was commented upon on two occasions, at 8 weeks and 14 weeks. At 14 weeks she was recorded to have been able to laugh, vocalise, turn to sound, and to follow objects. This is appropriate development for this age.

The newborn examination of Infant A undertaken within the hospital at her birth identified her to have a clicky hip. This information was provided to HV2 via Infant A's birth notification paperwork which also indicated that an ultra sound scan was planned for Infant A at six weeks of age. Clicky hip can be a feature of congenital dislocation of the hip which, if not identified, has implications for gross motor development. There is no evidence within the record that the ultrasound scan took place nor of HV2 following this up with the hospital.

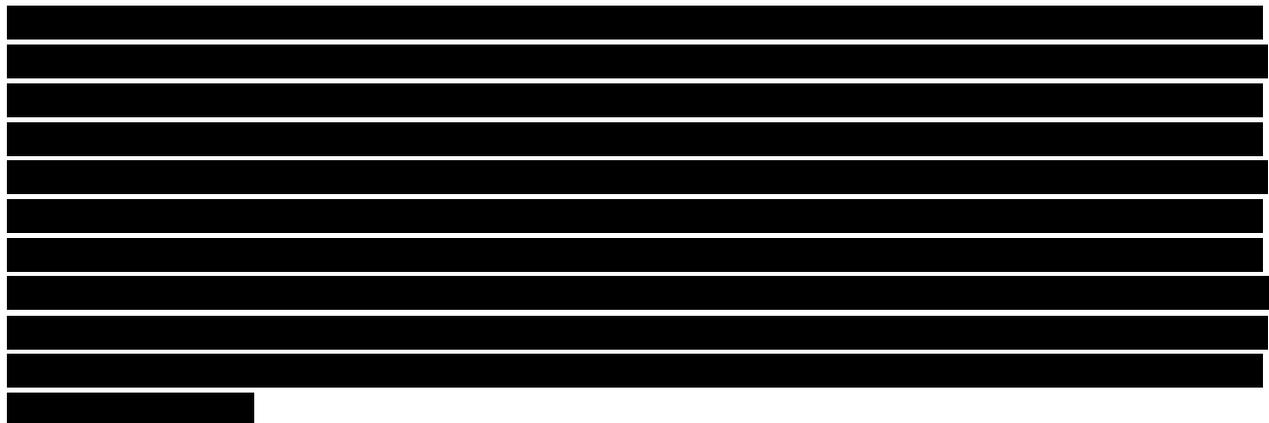
Infant A received two of her three primary immunisations at the Department Of Health recommended age appropriate times of eight weeks and 12 weeks. Infant A was mainly seen in the care of Adult B. After Social Care became involved in September 2010, Adult B reported to HV2 that she had been given a more formal role as a primary carer in that she had to approve where Infant A was taken by Child S.

The birth notification recorded Infant A's ethnicity to be Asian/White. The health visitor noted Infant A's father to be Asian. The only consideration/discussion around Infant A's ethnicity by HV2 was with SW1 when SW1 informed HV2 that Infant A had had her head shaved in keeping with Muslim tradition. HV2 had raised concerns at Child S's motivation to do this with SW1.

### **Analysis of health visiting contact with Infant A**

Contact by the Health Visiting Services was in excess of the requirements of the Child Health Promotion Programme and in keeping with a family identified to have additional needs. Infant A was found to be developing with expected milestones and to be gaining weight appropriately. Early weaning was identified at 12 weeks and subsequent advice appears not to have been followed with two weaning meals being offered by 14 weeks. It is noteworthy however that at the time Adult B raised her own children, weaning was recommended from three months of age. A recent review has questioned the appropriateness of delaying weaning until six months of age due to the risk of iron deficiency anaemia. Immunisations were attended at first invitation.

The availability of the historical case conference information would have afforded the opportunity for a wider assessment of the potential risks Infant A was exposed to.



### **Analysis of NHS Rotherham Community Services IMR**

The IMR author has analysed available material well and has been specific about appropriate timings and the terms of reference are answered. The IMR author has used the available information to analyse information effectively. The review is appropriately critical of some areas of practice particularly in relation to the multiagency working. The recommendations reflect key issues.

### **3.7 Overall Analysis of Involvement of Health services**

The purpose of the health overview report as described in Working Together 2010 is to focus on how health organisations have interacted together. The Health Overview author has reviewed the IMRs for each health organisation. For the purpose of this section the lessons to be learned identified by the Health overview author have be used to summarise the key additional issues.

The health overview author identifies the following additional lessons:

- That health staff needed to be tenacious in caring for Child S by ensuring that they analysed, explored and queried information. For example the Midwife asking who the Aunt was at delivery; what sort of conversation or risk assessment was undertaken regarding the ‘Gun’ incident; or what was the family understanding was around ‘being a Muslim’; and who if anyone had discussed contraception with Child S before she became pregnant.
  
- Strong working relationships between professionals and clients/patients are crucial to safeguarding children and young people, but trust needs to be placed with care, and ‘respectful uncertainty’ towards Child S and Adult B, and interest and curiosity in their narratives, needs to be part of assessment. To work with families with compassion but retain an open and questioning mindset requires regular, challenging supervision (Brandon at Al, 2009<sup>39</sup>). Supervision needs to be seen as essential to practice.
  
- It is important that health professionals worked closely together in sharing information about Child S, assessing her needs and those of Infant A and planning and evaluating her care. Whilst there are examples of good sharing and joint working there are many areas that required improvement. Health professionals had a considerable amount of information about Child S which if shared would have improved her care.
  
- Child protection work involves working with uncertainty. It is difficult to know for sure what is going on in families and no one can be sure that improvements in family circumstances will last. Managing that uncertainty is central to assessing the risk to the child. Risk cannot be eradicated services can only try to reduce the probability of harm. The big problem for society (and consequently for professionals) is working out a realistic expectation of professionals’ ability to predict the future and manage risk of harm to children and young people. The health IMR recommends developing a working party and clear definitions of ‘vulnerability’.
  
- Increasingly, health professionals are caring for patients and families from diverse backgrounds and cultures. Because ethnicity influences practice in many ways, it is important for a greater understanding of ethnicity and the ways in which it can influence individual’s perceptions and responses to problems and care. Knowledge and understanding have therefore become critical for effective practice. It is important health professionals provide culturally sensitive, holistic health care for a child or family. Cultural relativism is not adequately discussed in the majority of the health reviews yet it is a central issue for organisations to understand and work with. Child care professionals’ understanding of cultural diversity within and between families is essential to avoid professionals falling back into moral judgements which are often based on their own belief systems. This issue is currently prioritised in safeguarding supervision and training programmes and should continue to be a central consideration to ensure that understanding of cultural relativism is embedded into practice to support the drive to secure positive outcomes for children.

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<sup>39</sup> Brandon et al (2009), *Understanding Serious Case Reviews and their impact* (England, 2005- 2007)

- The health IMR authors all identify issues created by Child S's learning difficulties and Child S' ability to retain important information, in particular the TRFT IMR but the assessment required to plan for holistic care is missing. The additional issues faced by pregnant adolescents seem to be a gap in their evaluation. Teenage motherhood seems to have been well considered in particular the added value of the teenage pregnancy midwife interventions. However, the additional issue around Child S's difficult family history and lack of male role models does not appear to have been fully taken into account. This may well have been due to the fact that health staff saw Adult B as a resilience factor for Child S and Infant A and the fact that Child S was given the opportunity to continue in college and build a life for herself.
- Once Child S was identified as pregnant a number of health professionals had and took the opportunity to intervene and support her. The role and responsibilities of the teenage pregnancy midwife in conjunction with the teenage pregnancy support worker has recently developed to include the need to undertake a pre CAF on all those under 19 and a full CAF on those under 16. The Pre CAF is a checklist to support the active engagement of the young woman and her partner, assessing her/their ability to meet the five outcomes of Every Child Matters. The expectation of a referral to the health visitor during the antenatal period is also strengthened. The health overview author states that whilst completion of a CAF would not have altered the outcome for Child S as a health economy it may have been more apparent that a pre birth assessment had not been undertaken by CSCS as had been reported in all 3 IMR's. If a CAF had have been completed it should have resulted in a strategy meeting and hopefully an effective multiagency assessment and subsequent care plan for Child s and Infant A.
- The lack of engagement of Child S with some services in particular - historically with the CMO and NHS Learning Disability Team and latterly on occasions with the health visiting service - created difficulty in providing her with the care she required. RCHS have a guidance document that supports their staff in knowing what to do in these circumstances. At the time the guidance was only available to universal health services staff, namely health visitors and school nurses there has been a widening of the remit of Practice Guidance on the Refusal or Withdrawal from Children's Health Services'. Whilst in this case there is no evidence of lack of or chaotic engagement by Child S with the GP or hospital services the Practice Guidance on the Refusal or Withdrawal from Children's Health Services document would benefit from sharing with other health providers. Therefore an immediate action undertaken has been to disseminate the document with other health trusts via Rotherham Safeguarding Children Health Forum and the Named Professionals. The intended impact of this action is to provide other health trusts with the opportunity to consider how their No Access/DNA/Non Engagement guidance dovetails to support a seamless health service to children and young people in the borough.

### **Analysis of NHS Rotherham – Health Overview IMR**

The Health Overview IMR author has evaluated the content of the three IMRs well and has identified the key issues impacting on the delivery of health services to Child S. The terms of

reference are addressed and recommendations reviewed and additional recommendations added for completeness.

### 3.8 South Yorkshire Police

#### Analysis of South Yorkshire Police Involvement

The IMR author divides the analysis of South Yorkshire Police's involvement into:

- 2002 to 2008
- 2008 to 2010.

During the period 2002 to 2008 the police had only limited contact with Child S. However the contact was significant to early intervention in the behaviour of Child S and gaining insight into the behaviour of [REDACTED] and the parenting of Adult B. The contact included:

[REDACTED]

In 2005, police were called to the report that [REDACTED] had assaulted Child S. Officers attended and heard that Child S had allegedly been punched and kicked [REDACTED] was subsequently arrested and charged with this offence.

Later in the year, three further calls were received: one with regard to noisy youths outside the home address; another from [REDACTED] who was having a verbal argument with Adult B and the last that Adult B had been assaulted by [REDACTED]. Again, [REDACTED] was arrested for assault.

[REDACTED]

There were two further calls made which referred to arguments involving [REDACTED] which police attended.

[REDACTED]

In October 2006 the police received a call from [REDACTED] stating that Child S (aged 13 years) had gone missing from home. Whilst she was on the line providing police with the details of the disappearance, Child S returned home at 2 minutes past midnight. It was decided that no further police action was required. This was followed in December by a call from Child S who requested police attendance. Officers who attended state that an argument had taken place as a result of Adult B's refusal to allow Child S, aged 13 years, to go out of the house at 9pm at night.

[REDACTED]

In 2007 a call was made to the police relating to Child S stating that she had received comments of a sexual nature whilst in a take-away restaurant. Attempts by officers to engage with Child S to obtain a statement outlining what had been said to her were not successful as she failed to attend two appointments that were made in an attempt to gain details of the alleged offence. As a result the incident was closed with insufficient evidence to pursue any charges.

In February 2007 Child S (aged 14 years) was reprimanded having been found guilty of shoplifting.

In June 2007, at 1.50am, Child S, aged 14 years, was reported by Adult B as missing, returning however at 2.17am. The police recorded that they did not visit due to the short time scale between the initial report and her subsequent return, Child S was not recorded onto iTrace which is the South Yorkshire Police Missing Persons System. In 2011 a new Missing Persons' IT System is being developed. If the same call was received in 2011, the report would automatically generate a missing person's report which would be unique to that call. This would dictate that once Child S had returned, a return home visit would be necessary for the report to be closed.

In June 2007 Child S was found guilty of assault and warned about her behaviour.

[REDACTED]

In November 2008 a call was received from Adult B stating that [REDACTED] was assaulting Child S and herself. Officers attended the incident and were told that Child S had been assaulted with a belt and a chair and that Adult B had been punched. [REDACTED] was arrested as a result of this and was subsequently attended court. The incident was crime recorded in line with policy. It was correctly not recorded as a domestic incident.

[REDACTED]

In December 2008 Child S rang the police stating that she had returned to her family home to discover that it had been subject of a burglary and a TV had been stolen. In the March 2009 a call was received from Adult B stating that she had returned to her family home to discover that damage had been caused to the fencing outside her house. Both incidents were actioned in line with policy. In the first issue a suspect was subsequently arrested and charged. There were no suspects with regard to the second issue and therefore no further police action was taken.

[REDACTED]

In April 2009 a call was received from Child S stating damage had been caused to a window of their family home. An officer was dispatched to attend and it became clear that there were neither witnesses nor suspects to the offence. No further action was therefore taken.

In July 2009 police were called by Adult B who informed them that she had found Child S in the living room at 5am with two friends and an older man. During the call that was made, Adult B stated that according to Child S, the man had burnt her stomach with a lighter and kept touching her hand. Officers spoke with Child S who told them a different version of events. She stated that she had self-harmed in the past and the burn that she showed the officers was again one of self-harm in nature. She changed her account of events a number of times whilst the officers were at the address. She stated that the male with whom she had been was a family friend for whom she baby sat and that he had not caused any injury. No further action was taken.

On January 20<sup>th</sup> 2010, Child S was a one of a number of young girls that were discussed at a strategy meeting resulting from Operation Czar. It was reported that Child S had been present when her friend had been threatened at an address in Rotherham with an air pistol. Child S refused to provide any evidence to the police about what she had allegedly witnessed and this information was shared at the strategy meeting with partner agencies. An investigation subsequently took place into the air pistol offenders. Child S was spoken to by an officer in February 2010 with regard to the possibility that she was being sexually exploited as part of an investigation that was being conducted at the time. Child S was spoken to at her home with her Adult B present and was given opportunity to discuss any concerns that she may have had at that time. She stated that she did not get involved in any such activity and could take care of herself. As such, consideration of Child S's possible involvement as a potential victim in this operation ceased at that point.

The next contact with Child S was in September 2010 when police were called by Child S. She stated that she and her mother had argued and she had walked out and her mother was refusing to hand over Infant A and was questioning her ability to take care of her baby. When officers arrived, Child S was packing belongings for herself and Infant A. She told officers that she was adamant that she was leaving and she could not be persuaded by the officers to either stay with her mother, nor to leave Infant A in the care of her mother. Child S stated that it was her intention to stay at a friend's house and Adult B was of the opinion that this was not a suitable address. Adult B informed officers that she was afraid that her daughter would attend another house near to this friend and that this address was highly unsuitable for either her daughter or grand-daughter to attend. Child S was therefore spoken to about this matter and assured officers that she would not be attending at the address.



that she may have had at that time. She stated that she did not get involved in any such activity and could take care of herself. As such, consideration of Child S' possible involvement as a potential victim in this operation ceased at that point.

It is of note that the incidents above all focussed on police work that is routine except for the last issue which was related to an operation associated with sexual exploitation.

The incidents below are those where the IMR author has concerns about the way that they were handled.

In November 2008 when police officers attended an incident when [REDACTED] assaulted both Child S and her mother. Officers who attended the incident were said to have taken positive decisive action in that an early arrest was achieved. The crime recording procedure was correctly followed and [REDACTED] was subsequently charged. However, as the IMR author identifies there are then concerns about the lack of consideration given to the evident child protection issues. At this point, Child S was 15 years old and [REDACTED]: both were therefore classed as children under the Children Act 2004. Several officers attended this incident.

[REDACTED]. The officers who attended this incident should have completed a Child Protection referral to the Force Central Referral Unit by completing the necessary form (Gen 117) and also the Gen 118 Concern for a Child system. Had this been done, then the information would have been shared with Rotherham Children's Social Care. This would have triggered an assessment of Child S as a victim and additional, work could also have been carried out with the offender,

[REDACTED] None of the officers who attended the scene completed the necessary referral form. The IMR author confirms that all officers who attended know the difference between the two forms and all the officers have had Child Protection training which would assist them in recognising the signs and symptoms of child abuse.

Of course a check with Social Care would have identified that both Child S and [REDACTED] had been the subjects of Child Protection Registration in the past.

- The next incident was in July 2009 when Child S aged 13 years was found by her mother at 5am in the living room of the house with the 32 year old male. Officers that attended state that they established from Child S that she had self-harmed rather than her first claim that the male had burnt her with a lighter. Following this incident, one of the attending officers should have completed a Gen 118 A Concern for a Child Form. This is due to Child S having been found at 5am with a 32 year old male in the house and in addition, the confessions of self-harming.

Had this been done, then Social Care would have been made aware of the circumstances of these events. This was not done and an opportunity to share this information was missed. Both the officers who attended this incident have received training in the use of this form and the IMR author found that they had in fact completed them on attendance at other incidents. Whilst they recall attending this incident, neither felt that the circumstances warranted the completion of the form. The fact that this child at the age of 13 years was in a house at 5am with a man more than twice her age and her confessions of self-harming

should have constituted enough concern for the completion of the form. The IMR author stipulates that non-completion was not due to a flaw in this procedure, but rather an error in the judgement of the attending officers.

- In January 2010 Child S being present at a fire arms incident was shared with partners at the Operation Czar strategy meeting, it would have been pertinent for the officers who were in possession of this information to also submit a Gen 118A Concern for Child form. This would have put the flow of the information on a more auditable footing and should have resulted in a risk assessment.
- In September 2010, officers attended having been called. Adult B was concerned with regard to her daughter's ability to care for Infant A and Child S was leaving home with her daughter. The IMR author identifies that officers completed the Gen 118A form as they were concerned with regard to Child S's ability to take care of Infant A given her learning difficulties and in addition, the concern that she may take the child to the highly unsuitable address of a local man. The IMR author expresses concern that officers were aware of the address to which she and her daughter went to stay the night and, it is clear that this address had a variety of 'markers' against it, related to drugs, possible firearms and violent domestic incidents. This was clearly an unsuitable place for a young mother with learning difficulties and a 3 month old child. The IMR author has discussed the issue with the officer who attended the incident to establish the decision making process that allowed Child S to attend that address and whether they had considered liaising with the Emergency Duty Team. Checks carried out by the officer to which did not reveal the markers that are present on the address. The IMR author carried out the same check which the officer states were conducted and it can be seen that there are previous concerns re drugs at the address, but the firearms and domestic violence markers would not have become apparent unless a check had been carried out on any previous incidents that had occurred at the address. This check does not appear to have been done.
- The officer rightly completed the Gen 118A Concern for a Child form; however it was not fully completed. There is a risk assessment section on this form where the officer has to complete an assessment of the situation as they see it. The form poses questions about accommodation that the child is in and which the child will be remaining. The risk assessment that was done was based on the accommodation which Child S had left i.e. Adult B's home and not the house to which she went. The form poses questions such as 'Are there any issues which give cause for concern?', 'Is the house warm enough?', 'What are the living conditions like?' All these questions were answered, stating that there were no concerns about any of these issues. However, the officers that attended this incident only noted the address which Child S took her three month old daughter to. They did not establish what the living conditions were inside or the identity of anyone living inside the premises or if the people were suitable for Child S and Infant A to be staying with. Although the officers knew the right action needed in terms of completion of the form, they did not complete it to an adequate level. Had they done so, they would have revealed a great deal more information with regard to previous activity at the address, which may then have prompted them to contact the Emergency Duty Team at Social Care. The information that they did submit on the Gen 118A was shared with Social Care, but not until the following week. The IMR author established that the officer who completed the form states

that she understands how to use it and that she has completed the mandatory training with regard to Safeguarding and recognising the signs and symptoms of child abuse and neglect. The IMR author states that the form Gen 118A was fit for purpose in these circumstances but feel that in this instance, it was incorrectly completed by the officer who attended the incident.

████████████████████  
In ██████████ Child S was reported as missing. The IMR author identifies that it quickly became apparent that Child S' disappearance was suspicious in nature and that the area of the canal would most likely become a major crime scene. South Yorkshire Police adhered to the Rapid Response Protocol immediately cordoning off the area for forensic examinations to be conducted. As such, it was not appropriate for a joint visit to the scene of the death by a Senior Investigating Officer and a Paediatrician. The Protocol dictates that South Yorkshire Police in these circumstances should have immediately informed the Designated Paediatrician and Social Care of the death in order to facilitate initial and immediate information sharing and planning discussion between agencies. This includes decisions regarding Strategy Meetings, and whether to instigate S47 enquiries in relation to other children in the household. In addition, the Protocol states that in circumstances where there are concerns about other children in the household, discussions should take place with Social Care about their future care. Officers from the Public Protection Unit did attend a Strategy Meeting on ██████████ to this end. This had implications for the safety of Infant A.

The initial response by South Yorkshire Police to the disappearance of Child S was extremely thorough and in accordance with national guidance in relation to high risk missing persons. The officers who attended the initial report quickly ascertained that the likely outcome would be grave. Countless resources were quickly allocated to the incident to locate Child S: these included uniform and CID officers, staff from the Dog Section, Underwater Search Officers and the force helicopter was utilised in an area search. This activity assisted in a thorough search of the area and the subsequent recovery of Child S' body.

In terms of police engagement in Strategy Meetings to discuss the welfare and care plans for Infant A, again officers took part in this process in adherence to the Rapid Response Protocol.

However, with regard to informing the Designated Paediatrician and Social Care of the death, this was not done. Social Care were first alerted to Child S's death via information that appeared on the social network site, Facebook and made contact with South Yorkshire Police to confirm this information. This was poor practice in terms of information sharing with partners at an early stage.

The IMR author's conclusions identify that:

- Obvious human errors that were made by officers that had dealings with Child S and her family.
- These errors cannot be attributed to systemic failure and cannot therefore be interpreted into recommendations.

- The officers concerned understood the documentation that should be completed in relation to child protection issues
- Officers had received the required training. The training programme in relation to Child Protection and Safeguarding issues within the organisation is dynamic and on a rolling basis. This ensures that training can be revised and updated at times when new and up-and-coming issues are emerging.
- Most aspects of the Rapid Response Protocol were adhered to, although information sharing at an early stage with partners was not properly managed.

### **Analysis of South Yorkshire Police IMR**

The IMR Author has used available recorded evidence as the basis to have discussions with officers involved in all contacts with Child S and Infant A. A critical analysis has been made of each contact with reference made to key police policies and to expected practice. In the recommendations made the issue of auditing the completion of Gen 118A Concern for a Child form is addressed an issue that is not explicitly raised in the IMR but is significant. There is also a question about the involvement and management procedures of senior officers in quality assuring the records of police officers.

Additionally as the Overview Author there are concerns based on other local and national serious case reviews about the ability of police officers to maintain a child focussed and safeguarding approach particularly when dealing with what they see as routine contacts. This is not because of a lack of training or a reluctance of the police service to learn lessons from SCRs. The specialist police officers who work with issues of safeguarding, sexual exploitation and domestic violence where they play a key role as members of multidisciplinary teams are able to maintain a child focussed and safeguarding approach.

### **3.9 Conclusion Section 3**

The content of the IMRs paints a not unusual picture of mixed performance in meeting the needs of Child S and Infant A. A combination of factors, including organisational, systems, workforce, cultural factors and individual deficient practice impacted on the care provided for Child S. There is evidence of good practice in relation to the involvement of College1 and the overall health care received by Child S during her pregnancy and for Infant A in the early stages of her life.

However, there are areas of considerable concern. Of significance is that the care of Child S did not focus on her and her needs. She was almost invisible to some services. The impact of learning difficulties on her ability to make choices about her life and care was not considered by most services. The potential for poor outcomes for Child S increased significantly because of a lack of early intervention at a stage to address early signs of concern. The cost to Child S in terms of her emotional and psychological well being appears to have been considerable. There were missed opportunities to conduct a comprehensive assessment of her needs, including a risk assessment. There was no evidence of the use of the Common Assessment Framework. This resulted in a lack of a comprehensive plan of care developed with Child S to meet her needs Appropriate child protection or care plans, and reviewing processes were not in place. There is a lack of interagency and multi agency working in many instances.

Child S was a difficult child to work with and she readily disengaged from services, but some services enabled her to do this rather than supporting her to participate.

## **SECTION 4 LEARNING LESSONS. IMPROVING SERVICES**

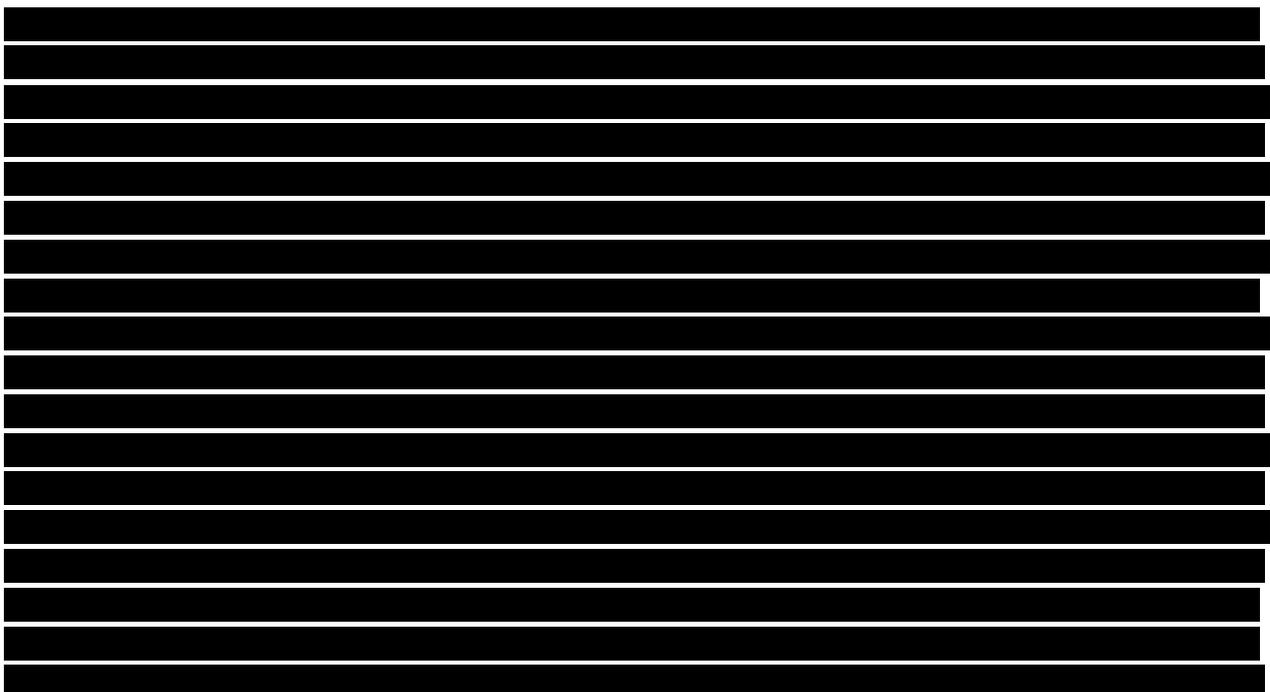
What is obvious from reviewing the IMRs from the different agencies that provided services for Child S and Infant A is that there has been a considerable amount of good practice but there is also a level of consistency in relation to areas of poor or inadequate care.

An analysis of the pattern of relationships that existed with professionals working with them revealed a number of repeating themes that continued to dominate the child / professional interface inhibiting an effective professional response. These have been identified as part of the lessons to be learned. Issues from the terms of reference that have not been explicitly or implicitly addressed in the IMR sections have also been addressed throughout but mainly at the end of this section.

### **4.1 A Child's Journey**

#### **Child S and Infant A's journey - child centred care**

Munro in her second interim report called '*The Child's Journey*', identifies the importance of analysis of the child's journey from needing to receiving effective help for problems arising from family and social circumstances. It is the intention in this part of the report to focus on Child S and Infant A and try to examine their journey and the lessons that can be learned from it. I have taken this approach not only because the emphasis is where it should be on the child but because what the IMRs and chronology show clearly is that few services actually saw Child S as a highly vulnerable child who society had a responsibility to protect. Adult B said at the meeting with her that '*Child S was very difficult but whatever she did not deserve this to happen to her*'.



[REDACTED]

Child S was involved with 15 different services during the seventeen years of her life. Her needs were never met. The information identified above was known either singly by an agency or was available to all agencies involved in her care if multi agency communication and working had been more effective. (The Services are identified at 1.2.)

The journey for Child S detailed above identifies many of the issues raised by Ofsted in their reviews of Rotherham Children's Safeguarding Services from 2008 to 2010. It should be noted that many of the issues identified are recent and in some areas current.

The lessons to be learned and the terms of reference that require further development are identified in the next section

## **4.2 Lessons to be Learned**

The Working Together<sup>40</sup> terms of reference (a) to (c) required in every SCR are reflected throughout the lessons to be learned. Specific terms of reference are identified at the end of the section as a heading prior to the response.

- a. establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children ;**
  - b. identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result ;**
  - c. Was specific consideration given to ethnicity, religion, diversity or equality that were identified and required specific consideration; and as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.**
1. Legislation in the United Kingdom requires that children are consulted about any decisions that will affect their lives (DoH 2001). Child S like many vulnerable children experienced low self-esteem, and self-confidence. A Child Centred Approach would have promoted her to choose, make connections and communicate. Child S was not really seen by any agency as the highly vulnerable child she was and the care provided by some agencies reflected the outcome of her vulnerability rather than addressing the cause. This can be seen in the approach of the school that lost sight of her for almost a year and the lack of development of a care plan by the Child Protection Conference Core Group or Children's Social Care or the Health Services recognising the difficulties created by her learning difficulties. Too often professionals took the word of Adult B at face value without considering the effects on Child S. Fundamental to the care of Child S was the lack of ability of the system to develop and sustain a child centred approach. There is some evidence in some IMRs of that but particularly in the case of social care, Project1, learning disability special services it appears that the service system pushed practitioners into prioritising other aspects of their work. Typically services supported Adult B to make many of the decisions and Child S only involved as a means to guide her into agreement with decisions that have already been

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<sup>40</sup> Working Together to safeguard children 2010 DCSF

made. Child S did not seem informed of alternatives or prepared for involvement. Hart's<sup>41</sup> recommends a model that is *child initiated and directed* and *child initiated and shared power*, where the children hold the most power and control while adults only provide support or guidance when needed. Work would have been needed to develop Child S's self-confidence, self-motivation and feeling of empowerment but it is an approach that was more likely to gain her support. There is evidence of this in the way that College1 was working with her.

2. This lack of child focussed care in the majority of the services resulted in limited or no consideration being given to Child S's special needs. As identified in the report she was very adept at covering the problems her disabilities created but this was said to be at superficial contact and that more time spent with her would identify the fact that she could not grasp issues or remember more than a small fraction of what she had been told. The impact of this on her understanding of a number of contacts with services would have been considerable. It is crucial that services are able to establish the impact of a child's special needs not only on their development and understanding but to inform therapeutic intervention.
3. Some practitioners lacked the ability to critically analyse data and information to identify indications and patterns of safeguarding issues. This was a crucial issue in relation to making an effective assessment of Child S. Contemporary practice calls for the ability to use assessment tools and techniques, objective measures and a systematic approach and to constantly strive to advance practice to have well developed observational skills, the ability to identify patterns and predict outcomes, identify escalating risk and ensure that reflexive practice is at heart of assessment. There were numerous missed opportunities to work with and protect Child S and Infant A. Assessments of Child S did not lead to an effective plan of care which resulted in a lack of leadership, coordination and stasis and the recognition of her real level of vulnerability. Child S was too speedily moved to a Child in Need status and removed from contact with services usually because of disengagement. Assessment must be one of the cornerstones of working with children and young people. All assessments must be underpinned by a sound understanding of children's developmental needs. The Framework for the Assessment of Children in Need and their Families<sup>42</sup> and the CAF could have been used for assessing the needs of Child S and Infant A but was never completed. Examination of the chronology identifies that some of the decision made to end contact with services were made at a point when Child S was at her most vulnerable for example in the case of social care. Some practitioners recognising this expressed their concerns as in the case of the head teacher and the health visitor, Project1 and the teenage pregnancy midwife, but their expert opinion was not regarded by Children's Social Care. Across education, health services and social care, assessments were different and the thresholds for securing additional support were at widely varying levels. Practitioners need to develop an 'assessment mindset' so that every encounter with a child is seen as an opportunity to re-evaluate their work with them in the light of new information. The history of the family was available to most of the agencies and individual practitioners if they had taken the time to make a fully informed assessment and therefore develop a case management

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<sup>41</sup> Hart, R.(1992) *Child's Participation: From Tokenism to Citizenship*, UNICEF, International Child Development Centre, London

<sup>42</sup> Framework for the assessment of children in need and their families. Doh 2000

plan. As the situation deteriorated the level of vulnerability of Child S and Infant A was not systematically evaluated and therefore the skills, knowledge and support of additional services were never effectively requested or addressed. There was a lack of a dynamic response to new and changing information.

4. The Child Protection Conferences and strategy meetings held about Child S played a significant role in assessment of her and decision making about her care in 2004 and this influenced her continuing care during the period of the review. Child protection conferences and core group meetings should have:
  - Been administered efficiently
  - Been attended consistently
  - Been managed authoritatively
  - Been produced a systematic analysis of the care and abuse
  - Produced decisions which were child-focussed,
  - Resulted in effective risk assessment
  - Consisted of key expert people to be able to assess the required information to inform effective decision making for example legal advice.
  - Developed child protection plans that are purposeful and authoritative and translate into the development of a robust action plan which in turn directs interdisciplinary practice and effective performance monitoring.
  - Reviewed options available to care for Child S and [REDACTED] given escalating problems. There is no indication in the minutes of the meetings that any advice or discussion took place about care orders for the children.
  
5. There was a consistently high threshold before concern triggered action and the attitude of the professional culture overall was too tolerant in its expectations of Adult B. There is also an issue of expectations of parenting and childcare being lowered by professionals because of what is considered to be generally poor standards of childcare in a community. Having systems in place to address the increased risk of providing services in areas of deprivation is crucial. The passive approach taken by some services is evidence that the challenges, and therefore the required systems and practice and the use of effective assessment tools, were not fully in place. An example of this is the incident with the gun which not only has significance for the safety of Child S but also Infant A and could have implications for all the professionals that have contact with her. The information was not treated with the seriousness that was required. There does not appear to have been any discussion about the use of legal powers when concerns about Child S from 2004 onwards needed to be escalated.
  
6. Munro and Laming recognise the importance of early intervention. There is sometimes confusion about what is meant by intervention in safeguarding and child protection. Procedures should place the practitioner in the right place at the right time to respond on behalf of their agency; Practice is the authority, understanding, knowledge and skills which the practitioner needs to bring to bear on the situation. It is necessary and important to follow the agency's procedures but it is responding with the appropriate practice that is also crucial. If they are not to trap themselves into inaction, practitioners must be prepared to work only with 'reasonable inference'. Reasonable inference is when agencies; follow and take full

account of the facts and make a proportional response to them without prejudice to the service user.

7. Poor co-operation, deception, and combination of plausible and disengaged presentation added to the focus being on ending services because of a lack of cooperation and losing sight of the real needs of Child S and Infant A. Practice became task focussed. Working with a disengaged child is a challenge to most experienced professionals and knowledge, skills and expertise needs to be developed and supported by effective supervision. It makes it even more important that a coordinated plan of care is established and delivered. In the case of the Child S the answer to working with a child who has difficulty engaging appears to have been to mostly end contact with her by closing cases, discharging her from health services. There were however examples of positive practice as in the case of College1 who attempted to secure/maintain her cooperation
8. The management of information within and between agencies and by individual health professionals is crucial to safeguarding children and young people. The quality of record keeping was also raised as an issue in many of the Individual Management Reviews although there is evidence of improvement in information systems and processes. Of particular concern was the documentation developed by Project1 that does not appear to meet information governance standards. Auditing of records remains crucial to ensuring that required standards are achieved and maintained
9. Many of the agencies failed to share information and as a result there was not the required level of shared analysis, planning and interagency practice. As the situation deteriorated the level of vulnerability of Child S was not systematically evaluated and therefore the skills, knowledge and support of additional services were never effectively requested or addressed. There is evidence of practitioners working in narrow silos for example School1 and GP. Professionals and agencies need to plan and assess laterally across families; giving consideration to safeguarding all children, not only the subject child. The focus of some agencies such as Children's Social Care Services tended to be on Sibling 3.
10. The level of Child S and Infant A's vulnerability appears not to have been risk assessed. The Framework for the Assessment of Children in Need would have assisted in risk assessment but it was not completed. Certainly as identified in the Youth Service IMR there appears to have been a lack of effective assessment in relation to Child S's involvement in sexual exploitation when the focus appears to have been on getting evidence to obtain conviction of suspected perpetrators. Once it was clear that Child S would not provide information to Operation Czar her ongoing needs was not assessed and additional support or help not provided. Risk assessments should identify the core features of the vulnerability of the child including:
  - Accurate identification of the risk the child is exposed to and why
  - The likely impact or consequences of the risks to the child
  - Whether the risks are externally posed or are endemic to the child and their circumstances
  - Whether the risks are acceptable.

Risks externally posed by others for example in the case of sexual exploitation are usually less acceptable. Risks arising from the person and their situation create a challenge for professionals because there is a balance to be made against reducing risk against impacting on choice, independence and autonomy of the individuals. For Child S the balance between the risk and her right to choose does not appear to have been considered and her ability to be able to assess risk for herself was not either. There was a birth assessment completed for Infant A which resulted in the case being closed. Given the identifiable risk factors it is difficult to determine how this conclusion could have been reached. This was recognised by the health visitor who contacted the social worker to express her concerns but this was ignored.

11. What could prove to be a very significant factor in risk assessing the service provision required for Child S and Infant A is the incident when Child S was present when men broke into a house and a gun was fired in a room where she was. As identified in the Youth Service IMR in previous reviews / enquiries of cases where people have met with violent deaths e.g. Richard 2004, London Criminal Justice Board (2009), there have been instances of violent behaviour on the part of the perpetrator that have been overlooked. Should the individuals involved in the gun incident subsequently be those convicted, this will be a critical point for lessons to be learned.
12. All professionals need to recognise the responsibility and accountability that comes with the role they undertake whether they are a Social Worker, GP or Midwife. They need professional maturity, the ability to respectfully challenge and an enquiring mind and the tenacity to see things through. There were a number of occasions when Child S was discharged from services or her case closed when there was no follow up to ensure that her care was being met by others or that people who had originally referred her were notified of the outcome. In the case of Child S it only needed one person to have analysed her situation and to have championed action for her needs to have been met more effectively. We will never know if the outcome would have been different.
13. There are a number of areas where there appears to be a lack of knowledge and understanding and should form part of training in the future they include:
  - Improved knowledge of sexual exploitation and grooming including a better understanding of perpetrators.
  - The role of fathers in the development and care of children and young people.
  - Assessment and critical analysis skills using assessment tools
  - Working with disengaged or hostile children and families.
  - Effectively monitoring the progress of families in safeguarding situations including managing risk, identifying patterns and predictive modelling.
  - Protecting children with special needs.
  - Formulating and sharing information and opinions – making yourself heard in the network
  - Challenging colleagues
  - Communicating and working with children
  - The management of information within and between agencies and by individual health professionals.
14. Lord Laming said that supervision is the cornerstone of practice. Whilst there is evidence of safeguarding supervision being provided in a systematic way in some agencies there is a

need for agencies to strengthen the structures that underpin supervision and to ensure that professionals access supervision and the right level of challenge, development and support.

15. Local Safeguarding Children Boards and the Director of Children's Services have a responsibility to ensure that the quality of care and services to safeguard children and young people are meeting required levels throughout Local Authority and partner agencies. Whilst Section 11 audits of services provides a process to benchmark current standards, and identifies both good and concerning practices the development of an assurance framework containing quantitative as well as qualitative evidence would be more effective. RLSCB needs to ensure that there is in place an assurance framework enables the assessment of the provision of safeguarding services to children and young people and that performance is monitored and managed against this.
16. There were issues associated with the effective management of services in relation to Project1 and Children's Social Care Services. It is important that there are clear lines of accountability and systems in place that support professionals to undertake their role. Lack of clarity about the functioning of services, asymmetrical changes within and across services, lack of resources and effective auditing, all added to produce an environment which made it difficult for professionals to achieve quality services. Kotter,<sup>43</sup> states management is about planning, controlling, and putting appropriate structures and systems in place, whereas leadership has more to do with anticipating change, coping with change, and adopting a visionary stance.
17. The complex nature of all public service organisations means that leadership is needed at different levels throughout organisations and not simply at the top. Leaders and managers of services The nature of professional practice requires individuals to be able to lead and advocate for the case management of their clients, patients and students and also to provide leadership as a member of a group or network. Professionals need to recognise the responsibility and accountability that comes with the roles they undertake. They need to have professional maturity, the ability to 'respectfully challenge', an enquiring mind and the tenacity to see things through.
18. Increasingly, social workers and other practitioners are working with clients from diverse backgrounds and cultures. Because ethnicity influences practice in many ways, it is important for a greater understanding of ethnicity and the ways in which it can influence individual's perceptions and responses to problems and care. Knowledge and understanding have therefore become critical for effective practice.
19. There was a lack of good interagency working. This is not just about sharing information (an issue raised in some IMRs) but about shared analysis, planning and interagency practice. The history of Child S and the family was available to most of the agencies and individual practitioners if they had taken the time to make a fully informed assessment and therefore develop a case management plan. As the situation deteriorated the level of vulnerability of the Child S was not systematically evaluated and therefore the skills, knowledge and support of additional services were never effectively requested or addressed.

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<sup>43</sup> What do Leaders do? Harvard Business review .68 103-111. 1990.

20. What is clear from the Serious Case Review is that there are considerable issues associated with safeguarding young vulnerable adults and the lack of understanding and systems in place to identify and address their needs. It is important that links are made between the planning and provision of safeguarding services for children, young people and vulnerable adults.

### **4.3 Terms of Reference**

**The review will cover in detail the period from 1st September 2008 until 14<sup>th</sup> October 2010.**

**A summary of agency involvement for the six years prior to this period (from September 2002) should be included in order to provide some history and context**

In line with the terms of reference above, the review has covered in detail the period from 1st September 2008 until 12<sup>th</sup> October 2010 and agencies have provided a history and context for a period of six years prior to the significant review period. In Section 2 there is evidence of all the good practice that is taking place in Rotherham much of which, once embedded, should address most of the lessons to be learned identified in the review.

**Any similarities with previous local Serious Case Reviews or national themes, their recommendations and subsequent actions.**

In *Learning lessons, taking action* Ofsted identifies that although there have been developments since Every Child Matters<sup>44</sup> there remains a challenge to ensure that effective learning and action results from every serious case review and that all services fully appreciate the role they play in ensuring this happens.

There have been recently a number of high profile cases of sexual exploitation in Manchester, Derby and Rochdale in which young vulnerable people whose history and behaviour is similar have been physically, emotionally and sexually abused.

The overview report produced by Derby City Local Safeguarding Children's Board (SCR BD09) which reviewed cases of sexual exploitation identifies many of the areas that have been identified in this review including issues associated with; early intervention, effective assessment, management of services, risk identification, staff supervision. The findings and lessons from the report and those from other areas have been used to inform this SCR. They include:

- Early intervention
- Increased risk of sexual exploitation predictable in vulnerable young people. Poor self image is a significant vulnerability factor in young people at risk of child sexual exploitation (CSE).
- Missed opportunities to assess significant concerns in relation to the other young women and comprehensive assessments were not completed.

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<sup>44</sup>

[www.everychildmatters.gov.uk/](http://www.everychildmatters.gov.uk/).

- The significance, if any, of culture and ethnicity in contributing to both perpetrator and victim profiles
- Early childhood experiences have a critical impact on later development, and need to be thoroughly assessed and understood,
- A parent's own history and lifestyle has a significant impact on parenting abilities, and this needs to be assessed and understood
- Written records are an essential requirement of good case management in all agencies and must be completed and kept up to date
- Early assessment of the vulnerabilities of a young person using the Common Assessment Framework (CAF) must be improved, particularly in schools and health services
- 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
- 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
- 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.
- Good staff supervision and professional support is essential in enabling practitioners to deal with complex and difficult safeguarding issues.
- Staff in all agencies need to be better trained and equipped to deal with child sexual exploitation (CSE).

As part of this review, to identify what issues are current for Rotherham Local Safeguarding Children Board, SCR's completed since 2005 have been examined and the findings compared against those resulting from the Child S SCR .There is a degree of consistency across the SCR's associated with:

- Assessment – inadequate to inform safe and effective planning.
- Inadequate supervision and review.
- Slow – insufficient response.
- Examples of good and poor inter-agency working.
- Lack of clear and timely case recording.
- Issue of coordinated delivery of services and monitoring.
- Lack of accurate, clear information sharing at key points.
- Issue of early intervention.
- Children not heard.
- Thresholds too high.
- Significance of patterns not recognised.
- Escalation of concerns and referral an issue.
- Lack of therapeutic intervention.
- Need for constructive challenge.
- Exercise of professional judgement lacking.
- Risk assessment poor.
- Critical analysis of available information poor.

- Respectful uncertainty an issue.
- Discontinuity of services and gaps in services.
- Lack of management of CPC to ensure informed decisions / planning.
- Training, professional development and supervision.
- Impact of parental history on parenting not understood

Of concern is the fact that as a result of the seven SCRs RLSCB established seven action plans to address the recommendations from each review. Review of the action plans has found that the actions are identified as completed. There is evidence from this SCR to suggest that whilst the actions may have been completed the outcome of the actions has not impacted on the areas where change or development is required. This SCR has identified some issues of concern that are the same or similar as well as new areas that need to be addressed. The recommendations in the Child S SCR and subsequent actions need to be viewed against previous action plans to assess the effectiveness of action taken in the past five years. There have been substantial changes in the Children's Services over the last three years which are detailed in Section 2 with some examples of best practice and some of the changes when fully implemented should address lessons to be learned from this and previous SCRs.

**The review should primarily focus on the immediate family of Child S and Infant A but examine any assumption by agencies that the maternal grandmother, Adult B was the primary carer for and protector of Child S's baby, Infant A and that this became the focus of interventions, losing sight of Child S, as a mother and as a young vulnerable person in her own right.**

The focus of this review is mainly on Child S as Infant A was only four months old when Child S died. In the report leading from the death of Victoria Climbe Lord Laming<sup>45</sup> raised the issue of professionals being overly optimistic about the ability of parents to have the skills to meet the needs of their children not just physically but emotionally.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The Assessment Framework (2000) incorporates care giving behaviour in relation to attachment within the domains of parenting especially that of emotional warmth and this could have been used supplemented by additional tools. It is fair to conclude that services felt reassured by Adult B's presence and almost expected her to be the main carer. The only time this was challenged was when the GP practice asked for written permission for Adult B to bring Infant A for immunisations without Child S. The presence of Adult B provided a false security about the safety of Infant A and stopped what should have been a more detailed assessment of Child S's ability to care for Infant A. As this assessment was not made then the services that might have supported her were never identified.

**To consider how services support young parents where there are known issues that can impact on parenting capacity including where the parent has a learning difficulty.**

<sup>45</sup>The Victoria Climbe Inquiry report of an inquiry by Lord Laming 2003 DoH

The IMRs identify that whilst Child S received a good level of physical care and support from the teenage pregnancy midwife there was a lack of assessment by services of the impact of her learning disabilities on her ability to care for Infant A. Rotherham have done a considerable amount of work to reduce teenage pregnancy rates. That is why it is disappointing that none of the services discussed contraception with Child S or referred her to the specialist services like Project5 (young women's project) until she was pregnant. They have also improved services for pregnant teenage girls. The Joint Inspection report (July 2010) of Safeguarding and Looked After Children services stated that the Teenage Pregnancy Strategy was well implemented and provides a localised approach to data collection with improved access to contraception. It highlighted the targeted services which supports parents to talk to their children about relationships. It also identified Project5 which was said to provide effective partnership working with vulnerable young women who may be at risk of sexual exploitation, or have a number of high risk behaviours. In the project's first year, only one young woman out of 96 participants became pregnant. The project works closely with the Long Acting Reversible Contraception nurse (LARC), which the young people find to be of great benefit.

The TRFT IMR and analysis section of this report provides a more detailed review of the care received by Child S. The teenage pregnancy pathway was launched in November 2010 and should address some of the gaps in services experienced by Child S. The lack of information provided by Children's Social Care Services impacted on the ability of the GP and midwives to establish a plan of care to meet Child S's needs. Neither was a CAF completed. This has now been corrected in the pathway which will call for a pre CAF to be completed on young women under 19 and a full CAF for girls aged 16 years and under.

The fact that Child S had learning difficulties was not a central part of judging her capacity to parent or in the provision of information. There is no indication that the pre birth assessment conducted by the Family Support Worker which if completed using the Assessment Framework or any other parenting capacity tool to assess Child S's ability to parent Infant A would have identified potential risks. The first time that social care made an assessment was after the birth of Infant A and after that one visit the case was closed. This disregards the obvious indicators of risk associated with Child S and Adult B's ability to be able to keep Infant A safe.

There is no indication that any agency considered Child S's position in relation to the Mental Capacity Act .According to the Mental Capacity Act (2005) unless there is positive confirmation that they are unable to:

- Understand – a person is not to be regarded as being unable to make a decision if she is able to understand through the use of appropriate means for example; using simple language, visual aids etc.
- Retain that information – the fact that the person is only able to retain the information for a short period of time does not prevent him/her from being able to make a decision
- Use and weigh up the information and be able to communicate that decision- as part of the process of making that decision. It is not enough to just understand and retain the information the person needs to be able to consider the consequences of the decision.

There are indications from the IMRs that Child S would not have met the criteria for example analysis of the 3 health IMR's indicates that despite Child S was active in deciding her own health care needs and actually made very conscious decisions to seek health care when she felt it was required, for example attendance at the Walk In Centre and self referral to maternity services as 'baby not as active'.

NHS Rotherham is introducing in 2011 a pilot of the Family Nurse programme (FNP). FNP was introduced to England as an initiative to reduce social exclusion. FNP is a model of health led parenting support, developed by Professor David Olds in the USA. Licensed to the Department of Health in England the programme provides an intensive, preventive home visiting programme offered to vulnerable young mothers having their first baby. The programme uses methods based on theories of *human ecology, self-efficacy and attachment*, which are reflected in the model of practice, programme and learning materials and supportive tools. The programme is delivered by specially trained family nurses, drawn from health visiting and midwifery, is based on six domains covering maternal role, personal health, family and friends, the environment, resources, life goals. Family nurses are supported in this work by weekly supervision within a specified model. FNP supervision is supported by the local designated and /or lead nurse for safeguarding. This development, if it had been in place, would have provided the intensive focussed care required to meet Child S's need and should provide to be a valuable addition to services for young vulnerable women.

**Was specific consideration given to ethnicity, religion, diversity or equality that were identified and required specific consideration; and as a consequence, improve inter-agency working and better safeguard and promote the welfare of children**

Child S was part of a white British family and whilst there are no specific ethnic or religious needs to consider there were cultural issues associated with this family who lived mainly in deprived areas, were not in paid employment and experienced poverty. Around 60 per cent of children in poverty live in a household where no one works. Agencies did not appear to have considered the impact of poverty associated with class, income or deprivation on health, education and well being. Neither was this considered as part of a case management plan in relation to accessing and use of services or working with the family to gain employment.

Increasingly, social workers and other practitioners are working with clients from diverse backgrounds and cultures. Because ethnicity influences practice in many ways, it is important for a greater understanding of ethnicity and the ways in which it can influence individual's perceptions and responses to problems and care. Knowledge and understanding have therefore become critical for effective practice. However, knowledge is not the only factor necessary for establishing effective practice with clients. To a large extent, the development of these relationships depends upon the sensitivity of the practitioner to the culture and traditions of the client, and the ways in which these may influence behaviours.

In Child S and Infant A's case it was important to establish how Child S wanted to handle the fact that Infant A was of dual heritage. It also required an assessment of risk to both of them. There is reference made to Child S having shaved Infant A's head but little further assessment. Services of course had very little contact with both Child S and Infant A so it might have been an area of development if contact had continued.

## **How the parenting of Child S influenced her capacity and ability to protect herself and her baby Infant A.**

Neuroscience has shown how persistent neglect and trauma impacts significantly on brain development and functioning, leading to greater anxiety, impulsivity, poor affect regulation, hyperactivity as well as reduced ability in problem solving, empathy and sexual exploitation. The long term impact is seen in adult life with increased risk of depression, heart disease and substance misuse associated with adverse childhood experiences.<sup>46</sup> Research also has shown that teenagers who become pregnant are more likely to experience poor health during pregnancy<sup>47</sup>. There are also issues in the way that teenage mothers relate to their children because of neurological differences and intensive input is required to address some of these issues. Of course the risk increases as a result of Child S's learning difficulties. From a practical perspective Adult B stated that Child S could not read the numbers on the baby's bottle and intensive work would be required or an acceptance that Adult B would do that work with Child S or care for Infant A herself.

There were a number of issues known to most agencies that should have been identified by services in relation to Child S's ability to protect herself and Infant A. The main goals when Child S was pregnant was for services to work together to plan care that not only improves the outcomes of pregnancy by helping women improve their prenatal health; to improve the child's health and development by helping parents to provide more sensitive and competent care of the child; to improve parental life course by helping parents plan future pregnancies, complete their education and find work.

Previous UK research<sup>48</sup> has found that mothers who give birth for the first time before the age of 20 are later in their lives more likely to live in social housing, receive benefits, and have no qualifications, a low household income, poor health, mental health problems and a low satisfaction with life. Explanations of the adverse consequences of early motherhood often make associations with low educational attainment, which limits later employment options available to women, and low income. Their children are also more likely to have children while still in their teens.

There was an issue for Child S about her resilience and high level of risk taking (Cooper<sup>49</sup>). Services needed to help her to adapt to her new life experience as a mother. Resilience is also about having at least one secure attachment relationship which would have needed to be provided outside her home. She needed to be supported to bring some control over her life, good friendships and a sense of belonging to community.<sup>50</sup> Some of this was being developed by staff at College1 who listened to what she wanted and tried to meet her needs by adapting delivery of course content, providing additional support and talking to her about her needs as a mother. The College also provided the normality that she craved and she was developing friendships. She was

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<sup>46</sup> Gilbert, R., Spatz Widom C., Browne K., Fergusson, D, Webb, E., & Janson, S. (2009) 'Burden and consequences of child maltreatment in high-income countries', *Lancet*, 373:68-81.

<sup>47</sup> DCSF (2009) Teenage Pregnancy. Independent Advisory Group Annual Report 2008/2009. Crown Copyright 2009

<sup>48</sup> The report of the Independent Review on Poverty and Life Chances. Field. December 2010

<sup>49</sup> Cooper a risk and the framework for assessment 2003

<sup>50</sup> Werner protective factors and individual resilience 2000.

liked by the staff and her behaviour was good. College1 should be commended for the child centred approach they took to working with Child S and the way that they kept her fully involved in decision making when she left home with Infant A.

**The quality and effectiveness of continued assessment of risk and interventions provided to Child S and Infant A, given the known history of sexual exploitative relationships and Child S's learning difficulty.**

The IMRs and lessons to be learned in the next section identify the fact that there was very little risk assessment made of Child S and Infant A.

*“Assessments should be based on a set of theoretical constructs that guide the type of information needed and the sense that can be made of it. The theoretical framework should be the central reference point for selecting the observations to be made, formulating appropriate questions and giving meaning to the response. Otherwise the assessment is directionless and generates a mass of discrete pieces of information that cannot be organised or understood. (Reder & Duncan 1999 pg. 98-100).*

Assessments of Child S reflect the final statement in this quote in that it did not lead to an effective plan of care the result was that care was directionless; there was a lack of leadership, coordination and stasis and the recognition of her real level of vulnerability.

Professionals failed to listen and consider situations from Child's S perspective. They did not see her and, where possible, talk to her to find out what she thought and felt about issues; and to take action based on this information. The model of involving Child S in her care would have been crucial because of not only her learning difficulties but her lack of self esteem and disengagement with services. They did not recognise the 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.

However there is a growing awareness and application in practice in Rotherham of the need to listen to children. The CYPP identifies services listening to children but there are still issues of professionals who regularly work with children and young people developing the skills required for everyday listening and opportunities for decision-making in routines and activities; and one-off consultation about a particular issue, event or opportunity. There was very little evidence that Child S's learning disability and its impact on her ability to make decisions, her vulnerability to exploitation and her capacity to assimilate information and to parent effectively was ever fully assessed and met.

There have been times throughout agencies contact with Child S when a practitioner has attempted to encourage more definitive action to address an area of concern particularly in relation to sexual exploitation as in the case of Project1. The safeguarding network appeared 'stuck' .The necessary action to protect Child S was to escalate concerns at a managerial level between agencies. This option was not used as much as it probably should have been in this case and all too often practitioners failed to challenge their colleagues. Practitioners need to be aware of the process in place to escalate concerns and the necessity of using this mechanism.

## **The impact of the absence of information on significant adult males including the putative father of Infant A.**

The IMRs indicate that there was little reference made or importance given to the absence of information on significant males in Child S's life. Whilst frequent reference is made to the father of Infant A being unknown it is striking that Children's Social Care service records includes his name, something the family had previously refused to provide. Child S also told the hospital midwife. The assessment also states that Infant A's father's family "are not aware of Infant A's existence" a statement which was totally inconsistent with information provided previously. Had these inconsistencies been identified it may have been possible to have found out more about Infant A's father which may, in turn, have allowed a risk assessment to be made of any potential risk to Child S and Infant A.

Child S was said to be very upset that her father refused to have contact with her

[REDACTED]

[REDACTED] Whilst she told professionals that she did not want to have contact with him indications are that whilst she originally had not proposed to seek financial support from him that it changed.

## **The effectiveness of inter and intra agency working in relation to communication, coordination and information sharing on young parents who are significantly in need, have additional vulnerabilities of their own that may impact upon their capacity to parent.**

The Operation Central, Lessons Learned Review and IMRs identify the difficulties in inter and intra agency communication, coordination and information sharing. Problems of co-ordination reflect the sheer complexity of the services that some young people need.

Merely agreeing to work in partnership, or making a commitment to do that which is in the best interests of the child, does not seem to have made a difference. While all can sign up to it, it will mean different things to different people. What is needed is a common vision that is strong enough to bind all the agencies together while taking account of different perspectives and different points of departure. The Rotherham CYPP can provide that vision along with the Teenage Pregnancy Strategy and Pathway. It will require significant leadership from the Local Partnership, supported by a realisation from the leaders of its constituent organisations that such a common vision is essential, and must take precedence over any particular organisation's concerns. The future must be one of a holistic approach to the child or young person.

## **Sexual Exploitation**

Rotherham is no different from many other towns and cities across the UK in that the incidence of sexual exploitation is difficult to identify. For the purpose of the SCR, South Yorkshire statistics have been used. Whilst a significant proportion of children experiencing sexual exploitation are Looked After Children, statistics show that in Sheffield 70% of victims have never been in local



- The procedure for use of the service also has to be considered as presently referrals do not go to safeguarding in the first instance. Direct referrals to Project1 results in some at risk children not being known to safeguarding. There is no evidence of risk assessment or prioritisation or the procedure of handling children when they leave the service. In the case of Child S it was difficult to determine when her case was closed and when open, how she was risk assessed and her care planned and reviewed.

Part of the review should include assessing the potential for the development of Multi Agency Safeguarding Hubs (MASH) which would have three key functions:

- Identification of need and early intervention to prevent harm by working with the Early Intervention and response service to meet children and young people's needs that do not meet the threshold for CYPS.
- Harm identification and reduction – by identifying those experiencing the highest levels of harm and ensuring partners work together to support them with harm reduction services and strategies.
- Co-ordinating partner agencies working with vulnerable children and adults. MASH will impact on the way that early years and childcare providers make referrals when there is a safeguarding concern. Previously any safeguarding concerns about a child were referred to Children and Young People's social care services. The current referral consultation service will be incorporated into the MASH.

**Consider whether the decisions and actions taken by the agencies involved were in accordance with policies, procedures and relevant practice standards.**

Local Safeguarding Children Boards and Directors of Children's Services have a responsibility to ensure that the quality of care and services to safeguard children and young people are meeting required levels throughout Local Authority and partner agencies. Whilst Section 11 audits of services provide a process to benchmark current standards, and identifies both good and concerning practices the development of an assurance framework containing quantitative as well as qualitative evidence would be more effective. Rotherham Children's Services have developed a Governance and Assurance Framework that has the capacity to enable individuals from frontline professionals to the LSCB to be able to assess the performance of services to meet the safeguarding need of the children and young people of Rotherham. Munro identifies the importance of effective structures but it is also about the commitment of every practitioner. Having an effective system of governance and assurance across agencies will be even more important with the challenge given the financial and workforce issues that each organisation is likely to experience over the next few years.

The complex nature of all public service organisations means that leadership is needed at different levels throughout organisations and not simply at the top. The nature of professional practice requires individuals to be able to lead and advocate for the case management of their clients, patients and students and also to provide leadership as a member of a group or network. Professionals need to recognise the responsibility and accountability that comes with the roles they undertake. They need to have professional maturity, the ability to 'respectfully challenge', an enquiring mind and the tenacity to see things through. Laming recognised the importance of a strong local spine of accountable leaders with responsibility located in the local authority as reflected in the current statutory framework. It is particularly important that, given all the changes

taking place within and across organisations, Rotherham ensures that the role of the Director of Safeguarding and Corporate Parenting Services continues as the focal point of professional accountability for child protection services within the local authority and that this is not diluted or weakened.

There is evidence of practitioners meeting policy, procedures and the required standard of practice but there are a number of examples where the standards required were not met.

Some of these relate to a lack of effective systems being in place and therefore structural issues for example the lack of completion of CAFs for pregnant teenagers, and Project1 and local management of Children's Social Care. In other incidents the issues are related to individual professional practice rather than structural for example police services and school health services.

There were also situations like Child S being absent from school without recognition, supervision, or a joined up package of education and training which do not meet education requirements locally or nationally. The flexi-schooling established by the school is covered by the Education (Pupil Registration) (England) Regulations 2006. These state that an approved educational activity is an activity which takes place outside the school premises and which is approved by a person authorised in that behalf by the proprietor of the school, and of an educational nature, including work experience and supervised by a person authorised in that behalf by the head teacher of the school. The same regulations indicate that the attendance register at the commencement of each morning session and once during each afternoon session must record in the case of every pupil whose name is entered in and not deleted from the admission register whether the pupil is present, absent, attending an approved educational activity within paragraph or unable to attend due to exceptional circumstances.

There are concerns expressed about the quality of management of Children Social Care Services and Project1. Of particular concern is the decision to allocate an unqualified social worker to work with this extremely complicated family and then not to provide an appropriate level of supervision.

### **The supervision of staff and the support provided in working with a child protection and complex children in need cases in relation to their level of knowledge and experience.**

Supervision is the process of which facilitates the identification of factors known to be associated with child abuse and neglect; signs of maltreatment, strengths and ameliorating factors in order to assess risk and intervene effectively to safeguard and protect children.

"Working Together to Safeguard Children, a guide to interagency working to safeguard and promote the welfare of children" (WTTSGC) DCSF 2010, states that:

*"Working to ensure children are protected from harm requires sound professional judgement to be made. It is demanding work that can be distressing and stressful. All those involved should have access to advice and support from for example, peers, managers, named and designated professionals."*

*Those providing supervision should be trained in supervision skills and have an up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children."*

(WTTSGC 2010, ch 4.) defines supervision as:

*“An accountable process which supports assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve agreed outcomes”*

The process of supervision, underpinned by appropriate training, seeks to ensure that meaningful assessments of individual cases are made; so that the families that need it most are identified, prioritised and receive the service in an anti-oppressive, anti-discriminatory manner that addresses the needs of all stakeholders. The main body of literature on supervision refers to four main functions;

- Management; to ensure that the supervisee is clear about their role, responsibility and accountability and that the worker meets the agency’s objectives and standards.
- Educative; to develop a supportive and positive climate in order to enhance the worker’s professional development, and to offer support in managing the tasks relating to the work.
- Supportive; to help the worker to deal with the emotional demands of the work and
- Mediation; to promote clear communication between the organisation and the worker.

(Towle, 1963; Pettes, 1967; Kadushin, 1976; Westheimer, 1977; Payne-Scott, 1982; Richards et al 1991; Sawdon and Sawdon, 1991; Morrison, 1993; Hughes and Pengelly, 1997; Morrison, 2001.)

The picture related to supervision is generally mixed with some areas such as health visiting having a system in place for supervision and the further work being required in relation to Project1 and Children’s Social Care Services. There has been improvement since the Ofsted inspection in 2009 but there is still work to do to achieve the required level that staff need for the right level of challenge, development and support. There is little evidence of the social workers involved in the care of Child S receiving safeguarding supervision.

#### **4.4 Overall Conclusions**

The SCR panel have assessed all available evidence and have concluded that a combination of factors, including organisational issues, systems, workforce capacity and capability, cultural factors and individual deficient practice impacted on the level and quality of care provided for Child S.

Child S was a vulnerable young woman whose needs were not fully assessed by any agency that had contact with her. Serious case reviews in the past have highlighted the importance of services, seeing, observing and hearing the child. Few services actually saw, observed and heard Child S as the highly vulnerable child she was and who society had a responsibility to protect.

Rotherham Children and Young People’s Services have already put in place many initiatives that should reduce the risk of this happening again however the changes will require determination and commitment not only from policy makers and leaders but also from every practitioner if they are going to be successful.

## **SECTION 5.0 - RECOMMENDATIONS**

The impact statements for each IMR are provided as part of the action plan for each agency. The impact statements for the overview author's recommendations are provided below each recommendation.

### **Overview Author Recommendations**

1. Rotherham Children's Trust need to ensure that the changes to services outlined in the Children and Young People Plan 2010 to 2013 are implemented and that the accompanying Assurance Framework enables the assessment of the provision of safeguarding services to children and young people and that performance is monitored and managed against this.

#### **Anticipated impact of recommendation for children:**

Rotherham Children, Young People and their Families will receive effective services that are commissioned and provided according to their needs; and the outcomes of these will be measured and acted upon.

2. There is every reason to believe that the way in which Child Protection Conferences are conducted in Rotherham is now very different and more robust than previously but it would be appropriate for RLSCB to assure itself that the current Child Protection Conferences are:
  - administered efficiently, attended assiduously,
  - managed authoritatively
  - produce a systematic analysis of the care and abuse
  - decisions which are child-focussed,
  - effective risk assessment
  - develop child protection plans that are purposeful and authoritative and translate into the development of a robust action plan which in turn directs interdisciplinary practice and effective performance monitoring.

#### **Anticipated impact of recommendation for children:**

The robust operation of the Child Protection Conference and Planning function is one of the cornerstones of multi agency work to protect those children at risk of significant harm, ensuring that risks to and needs of children are rigorously assessed and effective and timely multi agency plans are put in place to meet them.

3. The Strategic Director of Children and Young Peoples Service should as a matter of urgency review the role of Project1 as part of a whole systems review to meet the prevent, deter and treat needs of children and young people at risk of sexual exploitation and grooming.

## **Anticipated impact of recommendation for children:**

Children and Young People vulnerable to or at risk of sexual exploitation require a continuum of service provision from universal, targeted and specialist services, according to their needs; this should enable them to receive a seamless approach to engagement, assessment, support and protection.

## **Social Care IMR recommendations**

4. The Director of Safeguarding and Corporate Parenting Services should ensure that there is a clear line management structure so that all staff know who is responsible for providing their case supervision and there is clear accountability. This should be done with immediate effect.
5. The Director of Safeguarding and Corporate Parenting Services should ensure that work is undertaken by staff with suitable skills, qualifications and experience and with appropriate support and supervision.
6. The Director of Safeguarding and Corporate Parenting should ensure that wherever an assessment identifies the need for further action a care plan is written that clearly describe the action to be taken.
7. The Director of Safeguarding and Corporate Parenting Services should ensure that no case is closed until a Team Manager has seen evidence that all work identified has being required has been completed.
8. The Director of Safeguarding and Corporate Parenting Services should ensure that the function and conduct of strategy meetings is reviewed, in line with recommendation 7.4.6 of the Lessons Learned Review for Operation Central. In addition to the specific areas identified in that recommendation the review should ensure that;
  - a. Arrangements are put in place to ensure that the minutes of strategy meetings are placed on the record of the child to whom they relate. Where a strategy meeting involves more than one child each child's record should only contain that parts of the minutes that relate to them.
  - b. Arrangements are put in place to overcome the practical difficulties of considering numerous children at a single strategy meeting.
9. The Director of Safeguarding and Corporate Parenting Services should ensure that a procedure is developed that governs how personal information about a service user can be changed on the Information System. This should address who can make such changes and how information needs to be verified before it is changed.
10. The Director of Safeguarding and Corporate Parenting Services should ensure that all social work staff within Children's Social Care have the support and skills to enable them to recognise and challenge disguised compliance.
11. The Director of Safeguarding and Corporate Parenting Services should ensure that clear guidance for the use of Contracts of Expectations and a template for such contracts are

developed and disseminated to all staff that might use Contracts of Expectations. The guidance should include issues such as when and how they should be used and the need for clear arrangements for monitoring compliance.

### **Education IMR recommendations**

12. The Senior Director for Schools and Life Long Learning should ensure that by July 2011, guidance is issued to all Rotherham schools relating to recording practice in relation to pupil information (to include timetables, alternative curriculums, incidents and behaviour, assessments of need and risk, plans, and reviews).
13. The Senior Director of Schools and Life Long Learning should write to all Rotherham schools to remind them and request compliance with the requirements to record actual daily attendance of any pupil undertaking any off-site curriculum activity in strict accordance with the Education (Pupil Registration) (England) Regulations 2006 and its accompanying Guidance.
14. The Senior Director for Schools and Life Long Learning should ensure that by July 2011 revised guidance for the arrangements for the planning, implementation and review of alternative curricula are issued to all Rotherham schools and providers.
15. The Senior Director for Schools and Life Long Learning should by September 2011 commission a review of educational opportunities and support to school age teenagers who are pregnant or are parents and those aged 16 – 19 yrs.
16. Head teachers should ensure that any pupil identified with additional needs that cannot be met within school resources, are subject to the Common Assessment Framework and the Team around the Child approach.

### **South Yorkshire Police IMR recommendations**

17. Headquarters Public Protection Unit are to carry out an audit to ascertain the effectiveness and use of the Gen 117 and Gen 118A system within the Rotherham District via the dip sampling of recorded incidents.
18. Headquarters PPU are to organise briefing sessions with all staff at Rotherham District with regard to the Gen 117 and Gen 118A system.
19. Referrals to Social Care with regard to a child going missing should be made within 48 hours and this referral needs to be audit trailed

### **Youth and Targeted Services IMR recommendations**

The Local Management Review of Project1 broadly confirms two of the recommendations of the “Lessons Learned Review – Operation Central”. Most notably those at 7.2 and 7.3 in relation to

the need for a multi agency team to specialise in tackling sexual exploitation, and 7.4.6, the conduct of strategy meetings.

Some of these recommendations may already have been enacted but building on the above this review would recommend:

20. The Director of Community Services and the Director of Safeguarding and Corporate Parenting should ensure a shared risk assessment is agreed between agencies with agreed thresholds for intervention.
21. The Director of Community Services must review the placement of the project within Young Peoples Services to ensure that adequate safeguards are placed around the work of sexual exploitation and that governance arrangements are in keeping with those in Social Care.
22. That the work of the Project1 Project is subject to management oversight and supervision.
23. With immediate effect the Director of Community Services should issue guidance on recording standards and expectations.

#### **The Rotherham NHS Foundation Trust IMR recommendations**

24. The Ante Natal Clinic Manager will, by August 2011 ensure that midwifery services complete a Pre-Common Assessment Framework (CAF) with all pregnant teenagers in order to assess need and maximize on appropriate services which can be offered to improve upon outcomes for young mothers and their babies. The Named Midwife and Teenage Pregnancy Midwife and the Common Assessment Framework Team will audit compliance of this in November 2011.
25. The anticipated outcome of completing a pre CAF on all pregnant teenagers is to ensure that they all have an assessment to identify their capacity to appropriately parent an infant. The CAF to include capacity recording.
26. Staff training at groups 3 and 4 to include an understanding of the challenges of working with parents with a learning disability.
27. The TRFT safeguarding supervision policy should include a consideration of the 'Ten Pitfalls' (NCPCC 2010) as a framework with which to consider risk.

#### **Rotherham Community Health Services IMR recommendations**

RCCHS from April 2011 is now integrated with The Rotherham Foundation Trust

28. By September 2011 The Associate Director of Children & Young People Services, Rotherham Community Health Services will ensure that a pathway is developed from the Midwifery Service to the Health Visiting Service for the notification of pregnancies. This will include the identification of vulnerable mothers including teenagers

and potential risk factors. Antenatal contacts will be monitored centrally by the Performance Team.

29. By September 2011, the Named Nurse for Safeguarding Children Rotherham Community Health Services will ensure that training on the 'Practice Guidance on Refusal or Withdrawal from Children's Health Services' is rolled out across all community services that are accessed by children and young people. Audit of compliance with the guidance to be included in the Safeguarding Children Health Team Audit Plan 2012.
30. By September 2011, The Named Nurse for Safeguarding Children, Rotherham Community Health Services will work with the Named Midwife at the Rotherham NHS Foundation Trust, to produce guidance relating to the assessment of parenting capacity for teenage girls identified as vulnerable pre and post delivery. The guidance is to include the use of historical information, a template for recording the assessment and CAF as a planning process. Training in relation to the guidance will be included in the Safeguarding Children Training Programme 2011- 2012.
31. By September 2011 the Named Nurse for Safeguarding Children will ensure that training is available on understanding the equality and diversity issues specifically relating to vulnerable groups and the impact this may have on parenting capacity. This training is to be included in the Safeguarding Children Training Programme 2011- 2012.
32. By September 2011, the Named Nurse , Safeguarding Children, will ensure that all Clinical Team Managers and Nurse Specialists, Safeguarding Children receive training around the Safe and Well protocol and understand appropriate means for challenging other partner agencies in relation to decision making.

#### **GP IMR recommendations**

33. The Chief Executive of NHS Rotherham, by May 2011, to write to the Chief Executives of all NHS providers in Rotherham reminding them of the need to ensure that all liaisons are written in a format that readily highlights issues of concern in an accessible summary.
34. The Medical Director, by May 2011, to write to all GP Practice Managers in Rotherham reminding them of the need to have in place a protocol regarding the recording in GP records of all relevant information with an associated action comment. Use of the protocol to be assessed at the Quality and Efficiency Review 2012 with completion of a self assessment audit devised by the Clinical Audit Team.
35. The Named GP Safeguarding Children to liaise with the Named Nurse RCHS and Named Midwife TRFT, by June 2011 to set up a task and finish group to consider maternity pathways for vulnerable groups utilising the "safeguarding package" across universal health services to provide evidence of additional targeted services. . The Named professionals and Clinical Audit team to audit compliance by November 2011.

## Health Overview Report recommendations

36. The Director of Public Health, by May 2011, to write to all voluntary and statutory agencies re-iterating the consequences of teenage pregnancy and parenthood and the need to refer sexually active young people to contraceptive and sexual health clinics.
37. Named Professionals in Rotherham, by July 2011, to develop Group 3 safeguarding children training sessions to contain specific reference to practitioners need to maintain respectful uncertainty, professional curiosity and professional challenge.

## Appendix One -Glossary

**Project1** - is based within Young People's Services and is a standalone project within the Youth Service. Established in 2000 the original aim of the project was to provide preventative services for young women at risk. However over time they have evolved into a much more active role in supporting young women both at risk of and involved in sexual exploitation and providing information on alleged perpetrators.

**Centre1** - is a pupil referral unit which caters for pregnant girls and young mothers. It enables them to continue their education in this small unit which has nursery facilities attached. The centre is jointly funded by Barnardo's and the Rotherham Education Department, with Barnardo's being the registered provider. Funding from Rotherham Metropolitan Borough Council stops when a girl reaches 16 and to address this Centre 1 obtained additional funding to run a Parent with Prospects Course.

**Operation Central**- is the code\_name given to the investigation and prosecution in Rotherham of a large number of serious sexual offences alleged to have been committed by adult males aged 20\_29 against young girls aged 13\_16. 8 men were charged with a total of 2 offences of rape and 16 of sexual activity with underage girls. Five offenders were found guilty in September 2010. The men received a total of 33 years imprisonment.

**Operation Czar** is the code name given for an operation took place in Rotherham in 2009. It related to sexual exploitation of children and young people in a specific area of Rotherham. The operation did not result in any prosecutions because there was a failure to get victims to disclose offences and therefore to progress complaints.

**Safeguarding Pack** - Documentation in maternity records are commenced when there are safeguarding concerns at any stage in pregnancy. This will follow the baby if transferred to Special Care Baby Unit and be transferred in to baby medical records. This is specific to TRFT practice.

**Centile** - A statistical term to describe any of the 99 numbered points that divide an ordered set of scores into 100 parts each of which contains one-hundredth of the total. It is used in growth charts to plot where that child is in relation to another children and to plot a trend in growth. The 50<sup>th</sup> centile is the average or middle point.

**Child Health Programme** -The Hall committee assessed the evidence and produced guidelines as to best practice on assessing children's development. The latest guidance is version 4.

**Clicky Hip** - A name given to the feeling obtained on examining a neonatal babies hip. It needs tests and following up to ensure that there is no abnormality of the hip joint.

**IQ: Intelligence Quotient** - An intelligence test that is derived from standardized psychological tests of an individual's capacity to learn. The test results provide a score which is compared to the same age group. For instance, a score of 100 means that half of the population scores higher than you and half scores lower than you. A score of 100 is about average.

**Mental Capacity Act 2005, came into force 2007** - this applies to anyone over 16 yrs who is assessed as lacking capacity; this can be applied in a number of ways. It provides a legal framework for acting and making decisions on behalf of vulnerable people who lack the mental capacity to make specific decisions for themselves. The Act provides a statutory framework to empower and protect such individuals.

**Primary Care Trust (PCT)** - a group of free-standing statutory bodies within the National Health Service, accountable to their local strategic health authority. PCTs have responsibility for the health-care needs of their local community; their aim is to improve the health of and address health inequalities in their communities. They receive budgets from the Department of Health to commission and provide primary care and community services across the local area and to commission hospital services for patients.

**Walk in Centre NHS** – walk in centre are medical centres offering free and fast access to health-care advice and treatment. Centres provide advice and treatment for minor injuries and illnesses and guidance on how to use NHS services. You do not have to be a registered patient to attend, appointments are made as required. Rotherham Walk in Centre ensures that information is shared with the family GP.