Norfolk Safeguarding Children Board

Overview Report-Final

July 2018

Child Z Serious Case Review

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Confidential

Contents

Part 1
Introduction

1.1. Background to the SCR and Overview of Significant Events[1]

1.1.1. This Serious Case Review (SCR) is concerned with the sexual assault of Child Z, a 14-year-old male, by a 20-year-old male care leaver (YPA) in June 2016. The assault took place whilst the two males were being housed in temporary accommodation by a local District Council who was unaware of YPA's harmful sexual behaviour.

1.1.2. Child Z had been placed at the accommodation along with his mother and sister in January 2016 having been evicted from their previous rented accommodation by their landlord in November 2015. They were waiting to be rehoused in June 2016 and were eventually found suitable long-term accommodation in July of that year. There had been two referrals to the Norfolk MASH (Multi-Agency Safeguarding Hub) in 2014 but these had not needed any intervention by Norfolk Children's Social Care (NCSC).

1.1.3. YPA and his younger sister had experienced unsettling and difficult early childhoods which had resulted in both of them being taken into the care of Norfolk County Council when young. They were brought up together as Looked After children in a long term foster placement until YPA reached the age of fourteen. By all accounts, the placement met the children's long term needs for security, emotional attachment and stability. Unfortunately, it then broke down for YPA who experienced the move to another placement as a traumatic life event, seemingly impacting quite significantly on his sense of security and vulnerability. Whilst having good general health he had developed Attention Deficit Hyperactivity Disorder (ADHD) for which he received appropriate medication.

1.1.4. YPA developed inappropriate sexualised behaviour in early adolescence and in 2011, aged 14, was placed in a residential setting run by a private provider. He started to show signs of Harmful Sexual Behaviour (HSB) towards younger boys and in 2014 received psychological intervention to address the behaviour that included a risk assessment. The Norfolk Police and Norfolk Children's Services (NCS) were involved with YPA on several occasions in 2014-15 regarding HSB incidents.

1.1.5. YPA was subject to regular Looked After Child (LAC) Reviews up to his 18th birthday in January 2015, when he became a Care Leaver. As part of his pathway plan YPA moved into supported accommodation (a two-bedroomed flat) overseen by the residential home. He left the home on his own volition in the Spring of 2015 with no suitable accommodation and spent the rest of the year 'sofa surfing' with friends in the local area.

1.1.6. Regarding health matters, there is currently no dedicated health service commissioned for Norfolk's care leavers, who receive their last health assessment as they approach their eighteenth birthday. Given YPA's diagnosis of ADHD, ongoing health input beyond

[1] See Appendix 1 for Timeline of Significant Events

the age of eighteen would have been beneficial to support his pathway planning. In this case, the health services played a small part in the lives of both boys, both before and after the sexual assault incident. Health services were not aware of the sexual abuse incident in relation to either of the boys and were not included in any multi-agency decision making forums, such as the strategy discussions (see below).

1.1.7. YPA was arrested in December 2015 for the sexual assault of an 11-year-old boy (Child B) and bailed with conditions that he should not have any contact with the victim and not be alone with any person under 16. The Police informed his Personal Adviser (PA1) of the bail conditions.

1.1.8. YPA and PA1 attended an interview with a young person's accommodation agency (AA1) in February 2016. His application for accommodation was refused due to the risks he presented to young people.

1.1.9. YPA informed his personal adviser (PA1) in early May that he was homeless and needed somewhere to live. He duly registered in mid-May with the local District Council (DC)/Housing Options as homeless who made enquiries with NCS about his housing status. They were not informed of his bail conditions and placed him at the temporary accommodation on 24.05.2016 where there were several vulnerable children and young people resident with their families, including Child Z and his family.

1.1.10. YPA had been subject to a Child Sexual Exploitation (CSE) Perpetrator's Risk Assessment by Norfolk Police on 12 April 2016 and graded as Medium risk. On 10 June, the Police became aware that YPA was living in temporary accommodation and spoke to NCS about their concerns regarding the potential abuse of children living there. NCS agreed to contact the District Council/Housing Options service and obtain the name of the staff member who had dealt with YPA's homeless application and provide this to the Police.

1.1.11. Unfortunately, due to a set of mistaken assumptions by both the Police and NCS, each agency thought that the other was taking primary responsibility with the housing service for moving YPA. This resulted in a delay in moving him which eventually happened on 24 June 2016. Unfortunately, this was not in time to prevent the sexual abuse of Child Z sometime between 16 -19 June. The District Council Housing Options service only became aware of YPA's bail conditions and the ongoing Police enquiry from Children's Services (Leaving Care Team) on 24 June 2016, which prompted the move out of temporary accommodation.

1.1.12. YPA was moved by the District Council from temporary accommodation on 24 June. On the same day, Child Z's mother became aware of her son's abuse and made a complaint to the Police who arrested YPA that night. He was subsequently charged with the sexual assaults of an 11-year-old boy (December 2015 arrest) and Child Z in late June and early July respectively. YPA pleaded guilty to the charges and was given a custodial sentence in May 2017.

1.1.13. Child Z was risk assessed for Child Sexual Exploitation by the Multi-Agency Safeguarding Hub (MASH) on 27 June and graded as 'Standard Risk' and referred to Early Help. Subsequently, no support was offered. The family moved into new accommodation in July 2016.

1.1.14. A Serious Case Review was commissioned by Norfolk Safeguarding Children Board in November 2016 and work started in January 2017

Part 2

Aims, Terms of Reference and SCR Process Issues

The aims, Terms of Reference and information about the SCR Process are included as Appendix 2.

Part 3
Analysis

This report will now focus on addressing the four terms of reference. The analysis has, in part, been informed by the learning from the Practitioners' Event held in June 2017. Key findings, conclusions and learning points are set out in the next section.

ToR 1: Critically examine the effectiveness, or otherwise, of the care leaver planning for Young Person A (YPA). How well did the plan meet his needs for transition to independent living and address issues of risk assessment and management of his sexually harmful behaviour?

The Pre-Care Leaver Period-2014

3.1.1 The evidence indicates that YPA's needs as a looked after child, up to his eighteenth birthday, were largely well met by the staff during his time at the residential placement. His harmful sexual behavior had been recognised by the staff who had commissioned a psychologist (Psy1) in 2013 to risk assess and work with YPA.

3.1.2 A needs assessment before YPA's eighteenth birthday was required to inform an effective Care Leaver's Pathway Plan; one that would:

- contain an analysis (amongst other things) of his independent living skills
- access to suitable accommodation
- arrangements for future support and care planning; and very significantly,

- his potential risk around Harmful Sexual Behavior (HSB).[2]

3.1.3 An effective and very prescient needs assessment was completed by YPA's social worker (SW1) in October 2014. This identified two critical issues for his future, post care; namely, continuing therapeutic input from Psy1 (see above) to address his HSB and a transition to a semi-supported/moving on placement, as a 'bridge' to eventual independent living; overseen by the staff at the residential placement who had become very significant figures in YPA's life. This move would be dependent on YPA continuing and completing his NVQ apprenticeship which he was later to give up. Of note, the pathway plan needs assessment documented YPA's view that:

'*He is very frightened of becoming independent and leaving [the residential home]'*.

3.1.4 The needs assessment correctly identified that without these supports YPA's risks posed to younger children would significantly increase.

3.1.5 However, despite the LAC reviews of 2014 recognising the risk presented by YPA's HSB, there was no evidence of a risk management plan. In this regard, there was no reference made to the Norfolk Safeguarding Children Board procedures on, 'Abuse by Children and Young People who Display Sexually Harmful Behaviour', which had been issued in March 2014. It is not known why these were not followed although it may be that they were not well known by practitioners at the time. In addition, despite his work with YPA, Psy1 was not involved in any of the LAC reviews. Clearly, he would have had a very important role to play in informing the future risk assessment and management arrangements regarding YPA's HSB as a care leaver.

YPA-Post Eighteen; As a Care Leaver

3.1.6 On reaching eighteen years of age in January 2015 YPA became a care leaver[3] attaining the legal status of a, 'Former relevant young person'[4], making him eligible for supportive services from the local authority.

3.1.7 This meant (according to the Norfolk Children's Services, Care Leavers, 'Leaving Care and Transition' procedures and Norfolk County Council, 'Looked After Children and Care Leavers' Strategy', 2016-2019) that, regarding YPA, the local authority was statutorily[5] required to:

- Stay in touch with him.

[2] HSB, is defined as, 'Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult'. (Harmful Sexual Behaviour, NSPCC, Research in Practice, Durham University, 2016, p12)

[3] Defined as a, 'Young adult who has been in the care of the local authority'. (Norfolk County Council, Looked After Children and Care Leavers Strategy 2016-2019, page 4)

[4] They are aged 18 to 21 (or up to 24 if in full-time or further education) and have left care having been previously either, 'Eligible', 'Relevant', or both. (Norfolk Children's Services, proceduresonline, 'Leaving Care and Transition'

[5] Provided for under Regulations 4 to 9 of the Care Leavers (England) Regulations 2010.

- Keep the Pathway Plan[6] under review.
- Continue with the appointment of the personal adviser.
- Provide financial assistance to enable YPA to pursue education or training.

3.1.8 YPA was allocated a personal adviser (PA1) in March 2015 whose role was to, *'Act as the young person's principal source of contact in any matter relating to the pathway plan and is accountable for the effective implementation of the Plan'*. (Leaving Care and Transition procedures). The role also involved the co-ordination of other agencies and individuals identified in the pathway plan and to act as the 'focal' point in ensuring that YPA had access to appropriate services. PA1 was required to keep in touch with YPA, keep informed as to his progress and maintain a written record of all contacts. **When the care leaver moved to new accommodation the personal adviser must have seen them at that accommodation within seven days.** On each visit the PA was required to consider whether the accommodation continued to be suitable for the care leaver. PA1 also had the responsibility of initiating the review of the pathway plan and recording its outcomes. His manager at this time was TM1.

3.1.9 The Review learnt that PA1 had no previous experience in this role, albeit several years prior work with adolescents up to sixteen years old. At that time, there was a joint LAC/Care leaver service which had been judged by recent Ofsted inspections (2013/15) as being, 'Inadequate'. The Review heard that although the team manager (TM1) was, 'Good and knowledgeable', PA1 received no structured induction to what was a potentially complex and challenging job. The training received appeared minimal and did not cover the key aspects of roles and responsibilities. So, for example, PA1 was never given training on undertaking pathway needs assessment and planning. He also had no experience of, or instruction, in undertaking risk assessments of HSB.

3.1.10 PA1's first Pathway Plan Review/Progress report of 5 June 2015 noted that YPA had, in accordance with the previous needs assessment, moved out of the residential home at the beginning of March and into supported accommodation - a two bedroom flat- provided by the same agency. This arrangement seemed to be meeting his needs for a transition to eventual independent living. He was also noted to have had a good working relationship with PA1.

3.1.11 However, a critical episode in this case was the breakdown in YPA's training placement at the end of May 2015, which he terminated before its completion. This triggered the agency giving YPA notice on the supported accommodation as it was conditional on him completing the apprenticeship. The result was that YPA left the security of the agency and opted to make his own housing arrangements when it was acknowledged that the independence work was not completed. Concerns were noted by PA1 and the agency about YPA's direction in life regarding his attitude towards his apprenticeship, the uncertain outlook regarding his future and whether he was ready for independent living in his own accommodation. He was recorded as being in a same sex relationship with a

[6] This sets out the, 'Ambitions and route to the future for young people leaving care and will state how their needs will be met in their path to independence. The plan will continue to be implemented and reviewed after they leave care at least until they are 21; and up to 24 if in education' (Norfolk Children's Services, procedures online, Leaving Care and Transition)

young man of similar age and indicated that they intended to get married in the midterm future.

3.1.12 YPA had now entered a very uncertain and fluid time in his life where the previous key supports of the residential placement, the training scheme and the sessions with Psy1 were no longer there. In addition, he was feeling unsettled about his sexuality and had no family support to fall back on. These crucial elements had been '*key protective and resilience factor(s) in maintaining his self-esteem and social integration. Were (he) to lose (them) it increases the likelihood of boredom, social isolation and the prospect of offending',* as noted in his Pathway Plan Needs Assessment of October 2014.

3.1.13 In short, by the time of the Care Leavers Review (June 2015) the security of his previous long standing social and support networks were no longer in place. Moreover, the social controls and (limited) monitoring mechanisms overseeing his HSB from the previous pathway plan had been considerably diluted to the point where there had ceased to be any real sense of a concrete risk management plan. Although noting that YPA had finished his sessions with Psy1 and had not since displayed any sexually harmful behaviour, PA1's pathway plan review did not include a robust risk management plan or updated assessment[7] of YPA's potential for the likelihood of future HSB.

3.1.14 Indeed, YPA's HSB was not seen as an issue as he was thought to be in 'an age appropriate relationship'. PA1's focus was to ensure that YPA paid his rent and follow up the pathway into Employment, Education and Training (EET). Given PA1's lack of any training or understanding of HSB the absence of a risk management plan was unsurprising. Compounding this omission was that Psy1 was not invited to the review.

3.1.15 In summary, by June 2015, YPA had left the relative security and supportive environment afforded by his previous care leaver plan and was intent on setting out on a path of independent living, despite PA1 and the agency's concerns. In doing so he was now without the key supports of his former pathway plan and remained at an unknown, but not insignificant risk of sexually abusing younger children. Despite his LAC social worker having recognised YPA's risk in October 2014 and the previous assessment of Psy1, there was no risk management plan as part of the overall pathway plan. Indeed, PA1 had not seen the previous review minutes. Moreover, there seemed to have been little thought given to developing a contingency plan following the breakdown of the pathway plan.

3.1.16 Following a critical Ofsted inspection in July 2015 which continued to find the LAC and Leaving Care (Corporate Parenting) services inadequate, a re-structuring took place in September of that year, involving the creation of two separate services, namely the LAC and Care Leavers respectively[8]. PA1 was located into the newly set up Care Leavers team which was led by a new team manager (TM2). There was little evidence to show that the new team had received any meaningful induction or training on roles, remits, responsibilities and the development of risk management knowledge and skills in HSB

[7] For example, an AIMS2 risk assessment.

[8] Both services are located in each of the six local authority districts and overseen by a district head of social work operations.

and other hazards. The Review received information that the new manager (TM2) had not come from a LAC/Care Leaver background and had (reportedly) not attended the service launch and locality training. In short, the evidence available to the Review seemed to suggest a less than adequate preparation for the new service.

3.1.17 By the next pathway review in November 2015, PA1 noted that YPA had experienced numerous changes. This included moving to another part of Norfolk where he was sharing a house with a friend, albeit that the arrangement had come to an end in November due to the two falling out with each other.[9]YPA had also enrolled on a local college course in the September but had been excluded because of poor attendance, in addition to writing off a car in a crash. He was working on a part-time, unpaid basis in a restaurant, organized through the Department of Work and Pensions (DWP). These episodes reflected a significant degree of turmoil in YPA's life in negotiating the challenges of independent living.

3.1.18 PA1 expressed his concerns at the November review that due to the *'huge changes'* in YPA's life he had struggled with the transition from leaving the relative security of his supported placement, overseen by the care agency; and prematurely moving onto independent living. He had a headstrong attitude and a tendency not to listen to advice, choosing his own path instead. YPA seemed to be going from one crisis to another, not considering the consequences of his actions with his life appearing to be, '*Out of control'* at that time. The review concluded that progress with YPA's pathway plan was ineffective and that a *'new plan will have to be drawn up with YPA and this will need to be specific and realistic'.* There was no evidence that this was done.

3.1.19 Despite YPA's relatively chaotic and out of control existence, known risk factors that could increase the tendency for sexual abuse and aggression, the review concluded that *'YPA no longer requires therapeutic input, including both himself and others are no longer at risk……YPA does not pose as a risk to younger males and does not associate with them. YPA is currently in a relationship with a male slightly older……. who is proving on many levels to be a positive influence on YPA'.* This was YPA's male partner who was noted in November as self-harming and depressed.

3.1.20 This SCR is unclear as to what the evidential grounds were for concluding that, by the time of this Leaving Care review in November 2015, YPA no longer posed a risk of future sexual abuse to younger males. Especially so, given that PA1 and his manager (TM2) had received no training in HSB risk management and planning, nor had they accessed any specialist services to inform their views and decisions. How did PA1 know that YPA was not associating with younger males and what direct evidence, apart from YPA's self-reporting, did PA1 have about the, 'positive influence', or otherwise, of YPA's partner?

3.1.21 Was PA1 aware of the partner's self-harming and depression and the potential impact of these on YPA and their relationship? How aware were PA1 and his manager about the previous history of YPA's HSB? They had not read the key LAC report of October

[9] Possibly due to a suspicion in the household that he had sexually abused his flatmate's younger brother, Child B.

2014 and its prescient comments about YPA's risks around HSB, nor the earlier CSC risk assessment of July 2013. Apparently, PA1 had received no training on how to access 'Care First', (Norfolk's Children's Services electronic care recording system) which, in any event, was not easily accessible.

3.1.22 PA1 had seen Psy1's assessment reports of 2014 which had identified the degree of risk presented by YPA. However, PA1 and his manager were not familiar with YPA's early history of difficulties in childhood. In short, there was no formal risk assessment undertaken of the range of both static and dynamic risk factors appertaining to YPA's situation, nor involvement from Psy1, in the assertion that YPA no longer posed a risk of sexual harm to younger males.

3.1.23 In addition to the lack of a structured and formal risk assessment and management plan for YPA this episode raises questions around HSB recognition by Leaving Care staff, including managers, the extent to which YPA was visited by PA1,[10] especially after moving into the shared house, so as to gain an understanding of his situation, the frequency and quality of supervision; and very significantly, the degree of management oversight of the case.

3.1.24 How informed were the team managers regarding both YPA's pathway plan and the risks he posed of HSB? The CSC procedures for Leaving Care and Transition make it very clear that the designated manager for the Leaving Care team is required to approve and sign the pathway plan. There was no documentary evidence to indicate that this had been signed, by any of the parties, including the team manager and PA1. In relation to pathway reviews, the procedures state that the team manager or his/her nominee will chair these and that the team manager of the Leaving Care Service will retain a monitoring role, at six monthly intervals, to check the progress of the pathway plan. In principle, therefore the team manager should have been cognisant of YPA's case. Unfortunately, the lead reviewer was unable to speak to TM2 as she left the service of the local authority in late 2016.

3.1.25 Finally, it may be of some significance that the deterioration in YPA's situation in the latter part of 2015 and 2016, coincided with critical changes to PA1's working environment. Arguably, the re-structuring and re-purposing of the Corporate Parenting team into separate LAC and Care Leavers teams, the advent of a new manager (TM2) who appeared to be out of her depth and unsupported by higher management; and the demands for service improvement, would likely have created challenging conditions for PA1, and other staff to operate within.

Arrest of YPA in December 2015

3.1.26 YPA's arrest regarding the allegations of the sexual abuse of Child B[11], followed the strategy discussion about YPA's sister and friend, between the Police and NCS on the 8 December 2015. The manager of the Leaving Care Team (TM2) was present so it is

[10] A key task of the PA was to make an assessment of the suitability of any accommodation used by the care leaver, especially in the event of moves into unsupervised or unsupported premises.

[11] The allegation came about because of information from Child B's school.

presumed that she would have been aware of the circumstances of the incident. Consequent to YPA's arrest, PA1 was informed by the investigating Police Officer (PO1) of the bail conditions, namely for YPA to have no contact with Child B and not to be alone with a child under 16 years old. Therefore, it can be established that both PA1 and his manager knew of YPA's arrest and bail conditions. Indeed, the alleged offence and bail conditions were entered on Care First in January 2016.

3.1.27 It is of concern that there was no recording of the strategy discussion regarding the two girls as required by the procedures. Nor was there any sign of a strategy discussion in relation to Child B which should have been convened by NCS, albeit that it was open to the Police to have suggested one and, if necessary, escalated in the event of a disagreement. [12]The evidence indicates that there was no liaison between the investigating police officer and NCS (PA1 and his manager, TM2; the MASH) around, firstly, addressing the safeguarding needs of Child B and secondly, managing the potential risk of YPA. In compliance with the Norfolk Safeguarding Children Board (NSCB) inter-agency safeguarding policy and procedures, there should have been a strategy discussion and consideration of a S.47 enquiry regarding the sexual abuse of Child B.[13]

3.1.28 In the event, as well as a police enquiry, a separate social work assessment was completed with Child B and his family who were offered a Child in Need support package under S.17 of the Children Act 1989.

3.1.29 Regard should also have been given to the NSCB policy and procedures in respect to, 'Abuse by Children and Young People Who Display Sexually Harmful Behaviour', (see 5.1 of the NSCB safeguarding procedures) which had been in place since March 2014. The issue had been frequently and regularly disseminated on fifteen occasions through the NSCB partnership learning and development programme, between February 2013 to June 2015.[14]

3.1.30 The policy is underpinned by three key principles involving, firstly, a coordinated multi-agency approach, secondly, consideration of the needs of the alleged perpetrator separate from those of the alleged victim and, thirdly, the carrying out of an assessment of the alleged perpetrator.

3.1.31 Anyone having concerns that a child or young person might have abused another child was expected to refer these to the MASH, 'In accordance with the NSCB and Referrals Procedure' (see paragraph 4.1, Referral and Assessment of section 5.3, NSCB safeguarding procedures). Albeit that YPA was by this time an adult, he was still a care leaver and the responsibility of the NCS care leavers team.

3.1.32 Following procedures (see section 5.1.5), a strategy discussion should have been held. This should have led to the convening by NCS of a multi-agency meeting (see sections 5.1.6 and 5.1.7) chaired by the appropriate NCS team manager (TM2) and involving the

[12] See NSCB Safeguarding procedures (online) at section 5.1, especially paragraphs 4.5 and part 5 (strategy discussion).
[13] See Section 3.4 of the NSCB Safeguarding Procedures, 'Strategy discussions'.
[14] Information received from NCSB Workforce development officer, e-mail, 07.08.17.

social worker (in this case PA1), the Police (PO1, the investigating officer), any other appropriate agency and YPA, to consider the issues of risk assessment and management of his HSB and bail conditions. There should have been a written risk management plan (see 5.1.7.2) covering the identification of any child at potential risk from YPA, educational and accommodation arrangements, any future assessment if required, how the plan was to be coordinated, identification of a lead professional and a review process with clear timescales.

3.1.33 Why was there not a referral to the MASH, a strategy discussion and a multi-agency risk management plan as per the safeguarding procedures? Unfortunately, it was not possible for the lead reviewer to have spoken to TM2 as she had left the employment of the local authority some time previously. PA1 suggested to the lead reviewer that the induction and training given to him when he first joined the leaving care team in early 2015 was very poor. He was unsure of his role and remit as a Personal Adviser to care leavers, had experienced a team restructuring which was confusing and experienced a change of team manager which was unsettling. He had not received any formal training in, developing and writing care leaver Pathway Plans, HSB or assessment and management of risk. He reported having received only three or four supervision sessions between September 2015 to May 2016 (when he went off on sick leave), none of which were written up. He reported to have not felt well supported by his manager. He said that management oversight of casework was not good and that the team had had no Tier 4 locality manager for some time.

3.1.34 PA1 said that he did have a supervision discussion with his manager following YPA's arrest but the focus was on housing and EET (employment, education and training), not on the implications of the criminal investigation which was viewed as a police matter. It is against this difficult team backdrop that PA1, although knowing of YPA's arrest and bail conditions and on-going police enquiry (as did TM2) expected his manager to follow up with a multi-agency risk management meeting to address risk. It is not clear to the Review why she did not.

3.1.35 Regarding the Police, the evidence suggests that there was no discussion with PA1 on how to manage YPA's future risk, other than policing his bail conditions which were deemed to be sufficient controls in the circumstances. However, as discussed below, pre-charge police bail offered only limited control over YPA's behavior and actions; and since April 2017, arguably, even less so.

3.1.36 The omission by NCS to follow agreed multi-agency safeguarding procedures by holding a strategy discussion with the Police and other relevant agencies, consequent to YPA's arrest for sexual assault on Child B, was a missed opportunity to assess and manage his future risk of HSB and bail arrangements. Although there was a degree of information sharing, the lack of any follow up action was a breach of NSCB safeguarding policies and procedures and was not child focused. It is not understood why the procedures were not followed. The evidence indicates that the NCS and Police professionals involved in this episode were not cogniscent of safeguarding procedures around holding strategy discussions and taking appropriate actions in respect to HSB.

3.1.37 In addition, there should have been a re-convened pathway plan review held in December 2015 to consider the implications of YPA's arrest, undertake a refreshed needs and risk assessment and plan for appropriate accommodation, in light of the bail conditions. This would have been consistent with existing procedures, given that there had been, '*A significant change in the young person's circumstances'*. (NCSC, Leaving Care and Transition, p6).

3.1.38 By early 2016, PA1 was helping YPA to look for suitable accommodation and making efforts to find him a suitable employment/training placement. PA1 was clearly aware of the bail conditions and risk of YPA's HSB as evidenced by a Housing Agency's refusal in February to house YPA on these grounds. Likewise, his manager was aware.

3.2 ToR 2: How well were the needs, vulnerabilities and risks to Child Z and his family assessed and managed by agencies during the time they were homeless and in temporary accommodation?

3.2.1 Norfolk Children's Services and Norfolk Constabulary had not been involved with Child Z and his family prior to the sexual abuse incident in mid-June 2016. The local District Council/ Housing Options responded to the family's notice to quit from their landlord in November 2015 and discharged its duty under the Homeless Act 2002. The ensuing assessment identified that the family had presented solely based on the loss of their long-term accommodation and were in priority need of re-housing. The District Council considered that the risks associated with the family being homeless were far greater than those associated with them being placed in temporary accommodation. There were no other identified needs or significant vulnerabilities that required additional support or intervention from the District Council or other agencies.

3.2.2 As there was no suitable accommodation available at the end of 2015, Child Z and his family were offered temporary accommodation which they accepted and duly moved to in late January 2016. The accommodation was a privately-run Home with Multiple Occupation (HMO)[15] used by the District Council for temporary accommodation. Being private, the District Council did not run or manage it and did not have control over who resided at the property. The establishment accepted individuals from other agencies and local authorities which the District Council had no control over or knowledge of. The family were allocated a self-contained room and did not need to share any facilities which was in line with general practice around housing families in temporary accommodation by the Housing Options team.

3.2.3 The proprietors of the accommodation, in whom the District Council had confidence, were proactive in providing support to the residents and worked closely with Housing Officers to ensure that any issues with individual residents were quickly identified and addressed.

[15] Now no longer a HMO but unrelated to this case.

3.2.4 In conversation between the lead reviewer and Child Z's mother (MZ), the latter said that the owners were 'lovely'. MZ felt very welcome and she and the children settled in quickly. MZ was aware that she was sharing her living space with strangers and would take precautions, such as locking the door. However, overall she did not feel scared or intimidated by the other residents, including YPA.

3.3 ToR 3: Critically evaluate the efficacy, or otherwise, of inter-agency working, decision making and information sharing regarding the safeguarding of Child Z whilst in temporary accommodation. How child focused were multi-agency safeguarding actions (including Police bail management) and did they comply with existing local inter-agency safeguarding policies and procedures?

3.3.1 As previously mentioned, Child Z and his family had moved into their temporary accommodation in late January 2016 and were awaiting rehousing. Meanwhile, in mid-2016 YPA was 'drifting', with no tangible plans for pursuing his education and training, no suitable accommodation and subject to bail conditions for the alleged sexual assault of Child B and the ongoing police investigation. His contact with PA1 was sporadic.

3.3.2 YPA had previously been refused accommodation in February 2016 by a specialist housing agency because of the ongoing police enquiry regarding Child B and the accompanying bail conditions. He attended an interview for the accommodation with PA1, who disclosed the bail conditions when asked, with YPA's permission. Therefore, the risks he presented to children and young people were known to PA1 and his manager when he told the NCS Leaving Care team on the 6 May of his imminent state of homelessness.

3.3.3 By mid-May the following agencies were involved with YPA, namely:

- Norfolk Children's Services Leaving Care Team
- Norfolk Constabulary
- The voluntary sector Youth Training Agency
- The District Council Housing Options Service

3.3.4 There were several opportunities, between mid-April up to the time of Child Z's allegations of sexual assault in late June, for there to have been effective multi-agency responses to the YPA's HSB.

Police Child Sexual Exploitation Perpetrators Scheme

3.3.5 The first of these was the Police CSE Perpetrators' scheme which was part of the Multi-Agency Sexual Exploitation (MASE) team that, in turn, was part of the MASH (Multi-Agency Safeguarding Hub). It was introduced by the Police in February 2016 to allow them to focus on CSE perpetrators, and potential perpetrators, who were not the subject of other enforcement methods or restrictions. It offered several potential avenues for disruption, one of these being a referral to a multi-agency operations group meeting, which, at the time was held to discuss emerging victims, offenders and locations. The

scheme was in its early stages as a pilot, when YPA was subjected to it in April 2016. A key operational element was the risk assessment tool, the purpose of which was to:

'*Assess the risk posed by the perpetrator and in turn enable police to identify the correct response and application of tactics to:*

- *Reduce the risk the subject poses of CSE.*
- *Disrupt the pattern of behaviour they are engaging in.*
- *Gather intelligence or evidence to bring them to justice for any offences identified.*
- *Protect the community in which they are living or operating in,'*

(Norfolk CSE Perpetrator Risk Assessment, Appendix V1, 29.01.16, page 1)

3.3.6 As previously noted (1.1.10), YPA was assessed as being a 'medium' risk. The assessment included a mandatory check of several Police and other agency information platforms, including the NCSCCare First data base, which should have shown YPA to be a Care Leaver. This should have alerted the Police to an NCSC connection and identification of PA1 as YPA's worker. In any event, the assessment resulted in several actions aimed at mitigating YPA's risk and seeking to achieve the aforementioned four outcomes. Two of these actions concerned, firstly, alerting the local policing team to YPA's profile and secondly, making a referral to the CSE operational group for multi-agency tasking. At that time the group, which was at an early stage of development and in a, 'Pilot phase', was attended by a number of countywide agencies but predominantly by Police and Norfolk Children's Services.

3.3.7 The local policing team was alerted and did indeed take proactive, albeit somewhat delayed action, on 10 June, to investigate the circumstances of YPA's presence at the temporary accommodation. Although the scheme was at an early stage where systems and processes had not been fully embedded, there was no evidence to show that a referral had been made to the CSE operational group, or that it had considered a multi-agency approach to devising a risk management plan. Had this happened in May it is possible that YPA's whereabouts and actions could have been more effectively monitored and controlled and his bail conditions safely managed. Had these multi-agency risk plan arrangements been in place, YPA would not have been placed at the location where Child Z resided and would not have had the opportunity to sexually assault him.

3.3.8 The evidence thus suggests that on this occasion there was a lack of information sharing and no inter-agency working between the Police, the NCS and other agencies such as the local authority housing service and the specialist youth training scheme. The lead reviewer was unclear why there was no risk management plan developed by the CSE multi-agency operations tasking group and why this was not followed though in a timely way by the MASE team. The 'Pilot' nature of the scheme and its early development may have been factors militating against the above outcomes.

3.3.9 The CSE Perpetrator Review undertaken by the MASH on the 14 June did not make reference to the lack of a risk management plan. Moreover, there was no evidence of

any consideration given to the ongoing intervention by both, the local police team and the MASH, regarding moving YPA out of the temporary accommodation where Child Z was staying.

3.3.10 The learning from this practice episode highlights three key issues. Firstly, the crucial importance of ensuring that agreed actions resulting from CSE risk assessments, particularly those relating to risk management plans, are implemented in a timely and effective manner. Secondly, that they are followed up by line management. Thirdly, that effective interrogation is made of appropriate Police and other agency data bases to ensure that links are made with other on-going activities, such as local policing operations.

The Current Situation

3.3.11 Norfolk Constabulary state that the CSE Perpetrator Scheme has (as of August 2017) been in operation for around 18 months and that appropriate systems and processes are now in place. Over that time it has been developed and refined and is currently running 54 active perpetrators. The Police report that the scheme has become more efficient in highlighting individuals who pose risks and seeking to reduce those risks, albeit that there has, to date, been no formal external evaluation of its effectiveness.

3.3.12 Regarding the multi-agency operations group, this has seen intermittent attendees from various agencies and partners, including the Youth Offending Service (YOS), care homes and some local housing offices. However, in the last few months the operations group has evolved into the multi-agency risk panel, concentrating predominately on high risk issues (although with the ability to consider emerging issues) and is now run by Norfolk Children's Services. The Perpetrators' scheme remains single agency (i.e. Police) although several developments have been introduced to widen participation. [16]

Police Bail

3.3.13 It should be noted that there are two types of police bail, namely pre-charge and post charge. YPA was on pre-charge police bail from his arrest on the 11 December 2015 to being charged for the sexual assault on Child B on the 28 June 2016. Pre-charge police bail has little power in law to make it effective; so for example, if an individual is in breach of their pre-charge bail, they can be arrested but have to be released unless the enquiries for the original offence are such that a charge can be brought against the individual. The individual would be told at the time of being bailed that he/she could be subject to arrest in the event of a breach. YPA's bail conditions would have been recorded on the Police National Computer (PNC), so that, if stopped, or any police officer were to carry out a check, they would be visible to the person doing the check. Local officers would also be informed through daily briefings of anyone with bail conditions.

[16] See appendix 3 for details of developments

3.3.14 Moreover, pre-charge bail could be renewed without senior police officer or magistrates' oversight, sometimes for long periods pending the conclusion of police enquiries.

3.3.15 Thus, pre-charge police bail, in essence, acts as a deterrent.

3.3.16 Post-charge bail conditions have more legal powers attached in so far as an individual in breach of bail can be arrested, kept in custody and brought before the next available Court.

3.3.17 However, the Police and Crime Act 2017 introduced a provision in April 2017, placing a 28 day limit on pre-charge police bail, including any conditions. Since then, a one-off extension of up to three months can be sought but requires authorisation by a senior police officer, at superintendent level or above. In exceptional circumstances, where the police think it necessary to keep an individual on bail for longer, an application to a magistrate will be needed. An important principle underpinning pre-charge (police) bail is that it will be used when it is necessary and proportionate. Where it is not, the presumption will be that people will be released without bail.

3.3.18 Regarding the arrest of YPA in December 2015 and his pre-charge bail conditions, the actions taken by the Police and NCS have been analysed above in ToR1.

The Current Situation

3.3.19 Were a similar thing to happen now it is understood that the imposition of bail conditions on YPA (i.e. not to be alone with a child under 16) would be unlikely given the 28 day limit and the lengthy nature of sexual assault enquiries. Depending upon the seriousness of any allegations and notwithstanding the provisions for extending bail as set out above, it is the Police's view that YPA would now be released 'under investigation' with no restrictions at all. He would be free to stay where he wanted until such time as there was the evidence to charge him, which can often be some months later. At the point of charging he could then be subject to suitable post-charge bail conditions enabling risk management.

3.3.20 The new 28 day bail arrangements therefore suggest that in cases like that of YPA, the Police would have limited powers to risk manage such individuals. Therefore, in situations involving care leavers it is imperative that there is timely liaison between the Police, the NCSC/care leaver's service and other relevant agencies. Clearly, at the point of arrest the Police would not necessarily know that the individual was a care leaver. As per existing procedures, a referral would normally be made to the MASH resulting in a strategy discussion focused on safeguarding the child victim. The alleged perpetrator would be identified as a care leaver at the point of the strategy discussion and ensuing section 47 enquiry, following routine interrogation of agency databases.

Contacts between the Youth Training Agency and NCSC - May 2016

3.3.21 NCS was informed by the Youth Training Agency in May of YPA's homeless situation but there was no record of who at NCS received this. PA1, had been on sick leave since early May. No call backs were made by NCS to the requests from the Youth Training Agency for help in managing YPA's situation.

3.3.22 Given PA1's sickness absence it should have been incumbent upon his manager to have taken case responsibility for YPA's homelessness and wider needs as a care leaver. Indeed, he was due a care leaver pathway plan review in May. It is not known whether the information from the Youth Training Agency was received by the team manager of the Leaving Care Team (TM2) as there were no records. The evidence thus suggests that there was poor communication between the Youth Training Agency and TM2 regarding YPA's situation.

Contacts between TM2 and the Housing Options Team

3.3.23 Because this Review has not been able to speak to TM2 it is unclear precisely why she did not make reference to YPA's bail conditions and the ongoing Police enquiry in the e-mail sent to the Housing Officer on the 20 May 2016. The evidence from Children's services suggests that this was because TM2 did not want to breach YPA's confidentiality without first seeking his consent. Her rationale was that the Police were still gathering evidence on the alleged sexual abuse of Child B and that YPA had not been charged with any offence. A possible further reason may have been the expressed need to get YPA accommodated given that he was homeless and had been 'sofa surfing' for some time.

3.3.24 It was not evident that TM2 had considered the balance of risk between YPA's limited rights to confidentiality on the one hand and the imperative around the protection of vulnerable children and young people on the other; made explicit in this case by the Police bail conditions. Moreover, there was no indication that she had consulted with her line manager about the matter. Her apparent lack of understanding around inter-agency information sharing was a barrier to the safeguarding of children and young people. Had she been familiar about the guidance on information sharing and informed the housing agency of YPA's bail conditions it is highly likely that the housing team would not have allocated YPA a place where there were children under sixteen years old. .

Inter-agency practice between 9 - 24 June 2016.

3.3.25 There were several key factors accounting for the mis-communication between the Police, Children's Services (Leaving Care Team) and the MASH and the resultant lack of timely joint action, along with the Housing Options Service, to remove YPA from his temporary accommodation.

3.3.26 The first of these was PA1's sick leave absence from early May until August. This was a critical factor as there was no responsible personal adviser with knowledge about YPA's situation, *in situ,* until PA2's allocation on the 20 June. PA1, prior to his sickness absence, had been the leaving care team's single point of contact (SPOC) at the front

line, who along with his manager (TM2), knew about the ongoing Police enquiry into the assault by YPA on Child B and the accompanying bail conditions.

3.3.27 The lack of a personal adviser with case knowledge in a fast moving and fluid situation meant that there was no-one at the front line to liaise with other agencies and help co-ordinate an effective multi-agency response to YPA's homelessness and address the wider risk management issues.TM2's leave absence in early June compounded the problem.

3.3.28 PA2's involvement in mid-June came at a relatively late stage in the process. His role as an effective SPOC was handicapped by minimal management briefing, and a lack of a transfer summary, resulting in insufficient knowledge of YPA's background, current concerns and situation.

3.3.29 The second factor was a lack of effective management oversight, direction and intervention by the leaving care team manager (TM2) who was the primary case decision maker within Children's Services. She should have had the overview of YPA's situation and knowledge of his bail conditions and the ongoing police involvement. PA1 was given minimal supervision and direction by TM2 in his work with YPA prior to going on sick leave in early May. There was no evidence to indicate that any appropriate decision making or action had been taken by TM2 in concert with the Police, the District Council Housing Option Service and the youth training agency to assess and manage YPA's risk and bail conditions. This included, most importantly, not sharing information about his bail conditions with the housing agency when he became homeless and not taking timely action to move him from the temporary accommodation on TM2's return to work on the 13 June.

3.3.30 On the available evidence, TM2 appeared and poorly prepared for her role as the manager of the leaving care team. She, and the personal advisers, seemed to have limited understanding of general safeguarding practice and were confused about the limits of data protection and confidentiality. TM2 had managed a Child in Need team prior to being tasked with managing the newly formed leaving care team in September 2015, consequent to the Ofsted inspection of July 2015 and the restructuring of the former Corporate parenting team (see below). She did not attend the initial team orientation sessionsand indicated that there was little time for staff induction as work started to transfer relatively swiftly. Questions were raised by the Review as to how well she was supported and guided in her role by her line management?

3.3.31 The wider context for the leaving care service was of'nadequate Ofsted inspection judgements of services for care leavers and looked after children in 2013-2015.[17] This resulted in the Local Authority's overall children's services also being deemed 'inadequate' and subject to Improvement Board oversight and the expectation of a timely improvement in service outcomes for care leavers. Ofsted had identified that the authority had lost contact with 25% of its care leavers, that there were poor quality

[17] The most recent Ofsted inspection of November 2017 rated the Care Leaving Service as, ' Requires Improvement'.

pathway plans, with health, educational and employment needs not always adequately addressed. Moreover, service transformation had taken place within the context of several changes of senior management within Norfolk Children's Services during the period, which had created a sense of discontinuity for staff. The care leaving team operated within this wider organizational backdrop.

3.3.32 A third factor was the delay in re-allocating a new personal adviser (PA2) to YPA. Reasons for this were staff shortages and sickness, as there were reportedly only two PAs and the team manager working at the time, out of a full staffing complement of six PAs, one social worker and the manager.

3.3.33 Fourthly, as noted above, PA2, had not been adequately briefed by his manager or given a case transfer summary on being allocated YPA on 20 June. He knew from earlier conversations with the Police about the ongoing criminal enquiry and the need to re-locate YPA, although, reportedly, was not aware of his bail conditions.

3.3.34 Fifthly, the poor understanding by TM2 and the two personal advisers of the limits of data protection and YPA's rights to confidentiality and the need to override them in the interests of safeguarding children, was a major barrier to information sharing between the leaving care service and the District Council Housing Option Service. Compounding this was a belief within the care leaving team that YPA was a low risk to children and young people in relation to his HSB, despite his bail conditions.

3.3.35 Sixthly, given PA2's limited knowledge of the YPA situation, there were mistaken assumptions and understandings made on both his part and that of the MASH Police that the other party was taking active and timely steps to move YPA, via the housing options team, when in reality this was not the case. PA2's understanding was that he had been asked by the MASH police on 14 June to provide the name of the housing officer dealing with YPA's case. His understanding was that it was the housing team's job to find YPA alternative accommodation and that, in liaison with the Police, this would be done in due course. He did not see it as the leaving care team's role to relocate YPA.

3.3.36 PA2 said he was unaware of YPA's bail conditions when he passed on the required information to the MASH business support officer on 21 June, a few days after the sexual assault on Child Z. YPA's care leaver review of 21 June clearly indicates that there was a (mistaken) belief on the part of Children's Services that the Police were 'looking for a new address for YPA via the district housing team'. This belief may have been reinforced by the assumption that YPA had been seen by a police officer over the weekend of 11/12 June as suggested by the MASH police officer in his telephone conversation with the Children's service manager on 10 June (see above). In fact, there was no evidence that this had happened.

3.3.37 Another factor was the role of the Police in the episode. The case had been picked up in December 2015 and investigated by PO1, a CID officer, and the de facto SPOC in the

case. PO1 was not a child protection specialist and may not have been entirely familiar with safeguarding practice and procedures. The episode involved several police staff, ranging from the PO1, responsible for the Child B investigation and bail; the local team covering the area where YPA was residing; and the MASH officers, thus making for a degree of complexity regarding the Police response. Lines of communication between the three elements led to mistaken Police perceptions and assumptions that the care leavers' service was taking action in concert with the district housing service to re-locate YPA away from his temporary accommodation, when this was not the case. It would also seem that PA2 was unsure as to whom he should have been liaising with in the Police in the task of relocating YPA. Moreover, there was no timely police follow up with Children's Services to confirm that YPA had been moved.

3.3.38 In the event, contact was made by PA2 from the leaving care service on the afternoon of the 24 June requesting that the District Council move YPA. This was the first occasion that the housing team had been made aware of YPA's bail conditions and the need to move him, by which time Child Z had been sexually assaulted.

3.3.39 In short, each agency mistakenly assumed that the other was liaising with the District Council to move YPA, when neither had.

3.3.40 The practitioners' Learning Event identified that there should have been a multi-agency meeting jointly convened by leaving care management (TM2) and the Police on or shortly after 13 June following the MASH/ leaving care team discussion and agreement as to the unsuitability of YPA's placement at the temporary accommodation. In the opinion of the lead reviewer this was a further lost opportunity for multi-agency intervention to have moved YPA and thus prevented the sexual assault of Child Z.

3.3.41 Arguably, a strategy discussion could have been considered under the Norfolk Safeguarding Children Board safeguarding procedures (Section 5.1.5 'Abuse by Children and Young People who Display Sexually Harmful Behaviour'). Although a care leaver, YPA was legally an adult in June 2016. However, by virtue of his legal status he was still subject to the local authority's oversight as a 'Former relevant young person',[18] and arguably covered by the HSB procedures cited above.

3.3.42 These procedures under section 5 provide for ' *A co-ordinated approach between the agencies in Norfolk',* and the convening of a strategy discussion jointly by Children's Social Care and the Police ' *In relation to the alleged abusing child and the child victim where there is reasonable cause to suspect that the child concerned is suffering or likely to suffer Significant Harm..'* The strategy discussion could have also involved the housing options team and the training agency leading to a multi-agency, co-ordinated approach to relocating YPA.

[18] See notes 3-6 above.

3.3.43 For the avoidance of any doubt or confusion the lead reviewer would suggest that all care leavers (i.e. including those over eighteen years old) should be incorporated into the current NSCB HSB procedures.

3.4 ToR 4: Why did Child Z and his family not receive the appropriate multi-agency support services and Early Help offer, following the sexual abuse?

3.4.1 MZ reported the sexual abuse of her son to the local Police station at around 7 p.m. on Friday 24 June 2016. Coincidentally, YPA had been moved out of the temporary accommodation by the housing team and PA2 sometime after 4 p.m. on the same day and placed in alternate short-term accommodation. By this point the housing team had become aware from the housing officer with the Leaving Care Team of YPA's bail conditions. At the point YPA was moved neither the Leaving CareTeam nor the District Council were aware that an offence had taken place as Child Z's allegations against YPA were not made until later that day.

3.4.2 The Police, having established YPA's location, arrested him at 10.45 p.m. on Friday 24 June, on suspicion of having sexually assaulted Child Z. He was placed in custody. A child protection investigation (CPI) referral and CSE Perpetrator Risk Assessment notification was entered in the Police 'Night book' and for the MASH (Police) the next day. Because the notification was madeout of hours, (i.e. after 7pm) the referral was actioned overnight of 24/25 June (Saturday) by the uniformed sergeant who had located YPA. The local authority Emergency Duty Team (EDT) was contacted and informed by the MASH detective sergeant of YPA's arrest and custody. A charging decision would be made by the CPS regarding YPA and EDT would be told in due course.

3.4.3 EDT was given details of the alleged victim (Child Z) who was not known on the local authority recording system; in fact, he was known, but not as an active case. Of concern, it was noted that there were no EDT recordings of the information exchanges with the Police. At that point, the EDT worker should have raised a contact and referral (to the MASH) with the information shared by the Police. There were sufficient grounds for a strategy discussion in that Child Z had suffered significant harm. There needed to be a discussion regarding the plan for next steps and who was responsible for them. This did not happen and the incident proceeded as a single agency Police enquiry, when accepted practice would have mandated a joint enquiry. Why this did not happen is not known. It may have been that an assumption was made that the EDT would not have the capacity to assist.

3.4.4 The Police proceeded with the enquiry over the weekend. Child Z was ABE[19] interviewed on Saturday 25 June 2016. YPA was charged the same day and remanded to appear in the magistrate's court on the following Monday, 27 June.

[19] Achieving Best Evidence

3.4.5 The police Night Book was shared with other partners in the MASH at the 9.00 a.m. Monday morning meeting. A decision was taken by the assistant team manager (MASH, NCSC) not to proceed to a strategy discussion, possibly because the moment had passed, Child Z had been interviewed, YPA charged and remanded, and there was a high volume of work. A CSE risk assessment on Child Z was done by the MASH which resulted in a Standard Risk outcome and a referral to the Early Help and Family Focus service.

3.4.6 Reflecting on this Key Practice Episode at the Learning Event, MASH personnel agreed that there should have been a strategy discussion as per the agreed safeguarding procedures, either on the weekend (involving the EDT) or the Monday morning with the MASH/ Children's Services. This would, probably, have led to a Children and Family (social work) assessment and a Child in Need plan (under S.17 of the Children Act,1989) which, amongst other things, would have provided some post abuse therapy for Child Z and emotional and practical support for MZ and her daughter.

3.4.7 In addition to involving the Police about the ongoing criminal enquiry, a strategy discussion would have been an opportunity to have liaised with Child Z's school (it was only told of the incident by MZ and not Children's Services, see below), the Housing service and the Youth Agency Training provision (who were at the time working with YPA and were left in the dark about what was happening), to have provided a holistic and co-ordinated support package to Child Z and his family.

3.4.8 Albeit that the existing remit of the Sexual Assault Referral Centre (SARC) covers penetrative offences only and that the offence only came to light sometime after the incident, thus making problematic the recovery of any forensic evidence, the Panel took the view that consideration could have been given to referring Child Z to the SARC following the sexual assault. This could have provided a holistic assessment, including a forensic examination if required and screening for sexually transmitted diseases, as well as care of the victim to minimise risk of subsequent physical and mental health difficulties and promote recovery.

3.4.9 The Panel learnt that despite the current SARC remit, the SARC manager does consider the acceptance of other cases, dependent on the situation and the resourcing and capacity levels at the time. However, a referral for a non-penetrative sexual offence would be dependent on the police officer/staff member having the understanding and awareness that a particular case would benefit from such a referral. The Panel and lead reviewer thought that it would be reasonable to suggest that the SARC Board undertake a review of the SARC's remit and referral criteria.

The Early Help Offer

3.4.10 Regarding the Early Help referral; following the standard risk outcome of the CSE assessment made at the MASH on 27 June 2016, an Early Help referral (locally known as a CARF) was started the same day. This was finished on 5 July 2016 and put on DOREIS (Children's Services Early Help electronic system) on 14 July with an

expectation of offering support to the family following a Multi-Agency Sexual Exploitation (MASE) meeting and decision making. There was a delay, possibly due to there being a backlog for processing standard risk cases, until 22 July when the Early Help and Family Focus service (EHFF) attempted to contact MZ on her mobile phone. A further call was made on 26 July. On both occasions, MZ's phone was uncontactable. By this time Child Z and his family had been found suitable accommodation and had moved out of temporary accommodation.

3.4.11 A decision was made by EHFF management not to send a letter to MZ due to the temporary address, the time elapsing since the incident (over one month) and the unsuccessful attempts at contacting MZ. It was rationalised that the Police were still involved and a service was therefore not offered. Child Z and his family thus did not receive, or have the opportunity to consider, a timely support and therapeutic service.

3.4.12 Reflection on this episode by Children's Service for doing things differently suggests that the temporary accommodation could have been contacted to establish whether the family were still resident. A recorded delivery letter could have been sent to MZ rather than a standard post. Discussion could have been had with the MASH to see if a service might have been offered through the Police who had maintained contact with MZ and the family. Additionally, the case could have been passed to the Local Early Help team to continue attempts to contact the family. As there is nothing in the current processes to cover this situation there needs to be a review and change of procedures to reflect the learning from this SCR.

Part 4
Child Z Mother's Experience

4.1 In a conversation with MZ, the lead reviewer was told that life was stressful after the incident and that she had received no support from Norfolk Children's Services in the period after the disclosure. She would have welcomed some support for Child Z and herself, as she did not know what to say to him or how to manage the situation. She said that the Police, '*Were great while they were there but she had to do a lot of chasing. As time went on and Child Z moved on, she chased less.'* The Police could have provided better updates regarding progress on the enquiry and what was happening to the alleged perpetrator; was he locked away as she and her children were anxious that they might bump into YPA. She would have liked direction if he had turned up.

4.2 MZ informed Child Z's school in late June of the incident and she reported that the school generally handled things well, for example, by arranging for him to have some counselling. However, she was unhappy about the way that instances of Child Z being bullied were handled. The District Council Housing Options Service did as much as they could for the family, helped also by her local MP. She and the children are happy with their allocated accommodation.

4.3 The family eventually received support from EHFF after being advised by a local police officer to contact them. She did so in April 2017 and was allocated a family support worker (FSW1) who was helpful in assisting a school transfer for Child Z to the area where he is now living. FSW1 has seen Child Z on several occasions which MZ reported as good for her son. Child Z was reported by his mother to be happy in his new school and has made some new friends locally.

Part 5
YPA's Experience

5.1 YPA was interviewed by the lead reviewer and panel chair whilst in custody. The purpose was to hear from him directly about his experience as a care leaver and see if there was any useful learning to be gained for the SCR.

5.2 YPA was taken into care as a young child and, along with his sister, lived with foster carers until early adolescence. By all accounts the placement meet his needs for security and attachment and he was happy there. For various reasons the placement came to an end after eight years. He was very upset at having to move and said that, "The pinnacle of my downward spiral was when I moved out of (there)". He spent two short periods with a new foster carer and then in a residential unit before moving to a permanent residential establishment where he remained until leaving care on his eighteenth birthday. He said that this placement was a 'safe haven', somewhere he could 'plant roots', and became emotionally attached to the adults who ran the home.

5.3 YPA said that the therapy he had with Psy1 was difficult for him as he had spent many years building barriers and mental blocks to cope with difficult earlier experiences as a young child. He said that he would be taking part in therapeutic work in prison.

5.4 Regarding his care leaving experiences YPA couldn't remember many of the social workers he had but did recall PA1 whom he thought was a social worker rather than a Personal Adviser with the Care Leaver service. He was not clear of PA1's role and thought that the system was not explained clearly enough to him. He thought that the LAC Reviews were poor in quality and that, 'I was spoken about in the third person and mostly ignored'. He was not a child anymore and wanted more involvement. He was given a chance in 75% of the LAC reviews to speak to his social worker beforehand and thought that one of his Independent Reviewing Officers (IRO) became his social worker for a period of time.

5.5 He said that he gained seven GCSE's and through connections with the Home he started an apprenticeship but gave it up shortly before completion due to differences with the staff. YPA claimed that the decision to leave the apprenticeship led the local authority to stop funding the semi-independent flat provided by the Home which in turn resulted in him moving to stay with friends. He had no job and ran into money problems. He saw his PA who was trustful and reliable but seemed to be off sick or on holiday a lot and was not always available. It was up to YPA to contact PA1's manager to find out

whether PA1 was at work or ill. It was at this time (in mid to late 2015) that he wanted better access to employment from the Care Leaving Team and hardly ever saw his PA. That said, he did receive a lot of help from the Leaving Care Head of Apprenticeships in PA1's absence who, whilst sorting out his bursary also gave him some emotional support.

5.6 YPA thought the Leaving Care service, was not poor and was not good, but average. He felt that he had lost his 'safety bubble', namely the Home (where he had been for several years), the flat and the two senior care workers who had meant a lot to him, on having to leave the placement in March 2015." I was literally chucked out into the big wide world when I was nowhere near ready". On reflection, he would have liked to have stayed in care until he was 21.

5.7 On being arrested in December 2015, he was bailed which PA1 knew about. The Police were good as they, "Explained things clearly what I needed to do not to end up in trouble again", and he said that he managed his bail conditions well for some time. Things went downhill after this, he lost his accommodation and spent the next few months until May 'sofa surfing', with friends. He had no money and "was up the creek without a paddle". He did not want to contact the senior care workers at his old placement as he felt he had let them down and felt ashamed. He was unable to find any suitable supportive accommodation, for example with the specialist housing agency, because of the risk he presented from his bail conditions. This led in May 2016 to him lying to the youth training agency and the local authority housing agency about his bail conditions. He wanted "somewhere safe where he could put his head down".

5.8 Soon after arriving at the temporary accommodation in May 2016, he met Child Z's family and attached to them. He was also visited by the Leaving Care Apprenticeship worker who was not aware of his bail conditions. He was eventually reminded of his bail conditions by a local authority housing officer on the 24 June when he was moved and later arrested by the Police for the assault on Child Z.

5.9 YPA accepted that he had harmed Child Z because of his behaviour and was not in denial. He said that he had the mentality to change. He thought that it was important that children and young people who showed harmful sexual behaviour needed help in addressing it.

5.10 Regarding three key improvements to the Leaving Care service he suggested:

- Ensuring a continuous service by having a backup/contingency staff for service users.
- Clearly explain the care leaving system and provide contact numbers so that care leavers can access support.
- Provide support for care leavers when they leave prison and ensure that offender managers communicate with Children's Services/ Care Leavers' social workers so that they are supported while they are serving their sentences.

Part 6
Key Findings and Learning Points

6.1 ToR 1

YPA's pre-care leaver experience

6.1.1 Firstly, YPA's placement up to his eighteenth birthday met his overall needs very effectively. The proposed care leaver plan appeared, save for considerations about HSB, to have been a well thought out and informed by a sound needs assessment. YPA's proposed transition to young adulthood and independent living through the provision of supported accommodation, overseen by the care staff, and the continuation of his apprenticeship, were key elements in the pathway plan.

6.1.2 Secondly, whilst accurately assessing YPA's risk of HSB, there was no involvement in the LAC reviewing and care leaver planning processes by Psy1 whose contribution would have been helpful in addressing considerations of risk management.

6.1.3 Thirdly, the plan did not address how YPA's HSB risk was to be managed over the medium to longer term and was not compliant with existing NSCB policy and procedure. It did not follow through with a multi-agency HSB risk management plan. This is a recurring theme of the SCR.

YPA's care leaver experience

6.1.4 The implementation of YPA's pathway plan was sub-standard, did not meet his needs for the transition to young adulthood and independent living and failed to address the risks presented by his HSB. Reasons for this included the following factors.

6.1.5 Firstly, the preparation, induction, learning and development of the personal advisers in the leaving care team, before and after re-structuring in September 2015, were inadequate. The PAs were not clear about their role, remit and responsibilities towards YPA and had not received training in basic tasks such as developing robust pathway plans.

6.1.6 Neither PA1 (and PA2 as seen later) or his manager (TM2) received training in the assessment and management of HSB. As a result, there was no concrete risk assessment and management plan incorporated into YPA's wider pathway plan from leaving care in January 2015 to committing the sexual offences in July 2015 and in June 2016.

6.1.7 Management oversight, direction and supervision of PA1 was inadequate. There was no evidence to indicate that the team manager (TM2) had any meaningful involvement in the case by way of decision making or offering PA1 any constructive challenge.

6.1.8 There was no evidence of any contingency planning following the breakdown of YPA's pathway plan in mid-2015.

6.1.9 There seemed to be difficulties encountered by the PA in accessing Care First and attaining competency in its use. The importance of recording visits and contacts was not always recognised.

6.1.10 YPA reported that there was a need for care leavers to receive continuous service with a contingency back up for when PAs are not available through sickness or leave. It was important to ensure that care leavers were clear about the roles and responsibilities of PAs, their managers; and what support they were entitled to. There was a need to provide early intervention to address the needs and risks of young people exhibiting HSB. It was also important to provide support to those care leavers after their release from prison and ensure effective liaison with offender managers whilst serving custody.

The Care Leaver's Service: Ofsted and Recent Developments

6.1.11 The Service moved out of, 'Inadequate', to 'Requires Improvement', i.e. moving towards good, following the recent Ofsted inspection of November 2017. [20] This SCR notes that, " Young people who leave care are well supported by their social workers and personal advisers, who work hard to stay in touch and help them live independently and to follow their career or further education choices". (Ofsted: January 2018:8)

6.1.12 Ofsted reported that the service is making steady progress since the last inspection and that social workers and personal advisers prioritise care leaver's safety. However, not all areas of practice are yet good. In most cases, young people are well prepared for independence, although inspectors saw examples where young people were transferred too rapidly to the leaving care team, without adequate preparation. The restructure of the service resulted in a large volume of transfers in a short period. Pressures in staffing capacity in the receiving team meant that key actions, such as visits to young people, assessments and pathway plans, were not timely.

6.1.13 In response to a request from the lead reviewer to Children's Services to provide evidence of actions taken to improve the care leaver's service, the following comments were made,

"Children social care no longer considers acceptable to place looked after young people or care leavers, who are aged 16 and 17, in hotel accommodation. The introduction of the Locality Children's Resource Panel provides an additional scrutiny as commissioning of resources requires Panel discussion and approval. Learning and Development Programme for Personal Advisers specifically has been set up. Assessment of risks has been a theme that underpins many training sessions.When this Serious Case Review is published, specific learning sessions for the Leaving Care

[20] See Ofsted Report published 19 January 2018.

Teams across Norfolk County Council will have been rolled out. The Strategic Lead for Corporate Parenting chairs the Looked after Children and Leaving Care Service Development Group, where all designated team managers attend. This forum is used to embed learning and improve practice in risks assessment and management."

6.1.14 The SCR Panel and lead reviewer were encouraged to learn from the Ofsted report of the steady progress being made with the leaving care service and are keen to see this continue to the point where it will be rated 'Good', by Ofsted when next inspected due to consistently high quality outcomes for care leavers.

YPA's arrest in December 2015

6.1.15 Both PA1 and his manager, TM2, had been informed by the Police of the arrest of YPA and the accompanying bail condition. A strategy discussion between NCS (Leaving Care team), the area team in which Child B lived (assuming they were from Norfolk), health and the Police should have been held regarding the alleged sexual assault of Child B. The strategy discussion on the two young women should have been recorded in compliance with procedures.

6.1.16 There appeared to be a significant degree of unfamiliarity on the part of the Care Leavers staff and Police regarding the HSB procedures which were not referred to by either agency following YPA's arrest.

6.1.17 Overall, there seemed to have been a lack of knowledge and use of basic safeguarding and child protection practice as evidenced by not holding a strategy discussion on Child B.

6.1.18 Had the procedures been followed there could have been a multi-agency risk management meeting convened on YPA to monitor and, as far as possible, control his behavior, pending the conclusion of the police enquiry and the decision on charging. This episode was a missed opportunity to have done so.

6.1.19 There was a further missed opportunity to have convened a multi-agency risk meeting on YPA by not holding an early pathway planning meeting as set out in procedures.

Key Learning

6.1.20 *For NCS-Care Leavers' Service to consider.*

- Ensure that the Care Leaver Service continues making progress to the point where it has achieved a, 'Good', Ofsted rating and achieves high quality outcomes for care leavers.
- Ensure that the Care Leaver Service management is competent in providing effective oversight, direction, supervision and challenge to PAs.
- Ensure that attention has been given to the effective preparation, induction, learning and development of care leaver team PAs and managers, including competencies in needs assessment and pathway planning, risk assessment and management, basic awareness around the safeguarding of children, when to convene strategy

meetings, use of ' Care First', involvement in multi-agency planning meetings, recording and awareness of HSB issues.

- The need for involvement of HSB specialists, when appropriate, in risk assessment and management planning of Care Leavers and other young people, through LAC Reviews, Pathway Planning Reviews and multi-agency risk management meetings.
- The need for early intervention with assessment, treatment and risk planning of young people, including care leavers, who exhibit HSB.
- The need for care leavers to be offered continuous support from the service, especially when the PA is not available through sickness or annual leave.
- The need for care leavers clear to be clear about the roles and responsibilities of their PAs and team managers and what support they are entitled to.
- The need for effective liaison between the service and offender managers when a care leaver receives a custodial sentence; ensuring that support is offered on release from prison.
- Ensure that the Care Leavers' Service understands the NSCB Information Sharing Policy and knows the circumstances under which an individuals' rights to confidentiality can be overridden in the interests of safeguarding children and young people.
- The need for leaving care team managers to be reminded that they act as the Single Point of Contact (SPOC) when PAs are on leave, on sick leave or otherwise unavailable so they can receive, respond and act on communications and requests from other agencies regarding care leavers.

6.2 ToR 2

6.2.1 Child Z and his family's needs were mainly focussed on being re-housed. There were no identified additional needs or vulnerabilities.

6.2.2 The placement in temporary accommodation whilst awaiting re-housing was appropriate.

6.2.3 Being a privately run HMO made it difficult and impractical for the District Council to carry out any assessments in relation to potential risks from other residents to MZ and her children. Through experience, the District Council had trust and confidence in the owners of the accommodation to ensure, as far as possible, the health and safety of its residents.

6.2.4 In this instance, the District Council was not informed about the ongoing Police investigation and the accompanying bail conditions regarding YPA until he was moved on the 24 June 2016 at the behest of PA2, a few days after the sexual assault incident on Child Z.

6.2.5 The District Housing team's internal review has agreed that *'In the future, should a client (such as YPA) present with similar circumstances, [i.e. police bail conditions] then they would only be placed in accommodation that didn't have children under 16 and that this was approved by the probation officer or equal person supporting the client'.*

6.2.6 Moreover, all customers are now asked if they have any bail conditions or restrictions that present a risk to others.

Key Learning

6.2.7 *For Housing Options to consider.*

- Avoid placing children under 16 in temporary accommodation with shared communal facilities.
- Ensure that adequate safeguarding controls are secured throughout the procurement of temporary accommodation.
- Ensure that temporary accommodation providers are aware of safeguarding risks from individuals that is compliant with data protection and confidentiality guidance.
- Ensure effective multi-agency information sharing between all agencies so that children are not placed in temporary accommodation with people who present a risk to their safety.
- Ensure that clients are asked if they are subject to any bail conditions, ongoing police enquiries or other restrictions that would present a risk to others.
- If possible, to arrange for a client who is subject to bail conditions, ongoing police enquiries or other restrictions regarding allegations of assault against a child or vulnerable person, not to be placed in accommodation that has children under 16; and that this is approved by the probation officer or equal person supporting the client.

6.3 Tor 3

CSE Perpetrator Scheme

6.3.1 Albeit in its early stage of development, the Police CSE Perpetrator Scheme having graded YPA as a medium risk in April 2016, did not refer onto the CSE operational group for multi-agency tasking. This was a missed opportunity to have developed a multi-agency risk management plan for YPA prior to him going to the temporary accommodation.

6.3.2 The CSE review on the 14 June 2016 appeared not have cross reference with Police intelligence concerning the ongoing MASH and local police interventions seeking to move YPA out of the temporary accommodation.

6.3.3 There was a lack of information sharing, minimal inter-agency working and a lack of effective decision making, which was not child centred (on potential victims) or seemingly, in compliance with agency policy and procedures of the time.

6.3.4 The ineffectiveness of the scheme in April 2016 should be seen in the context of it being at an early stage of development. Norfolk Police currently report that effective systems

and processes are now in place resulting in the scheme being more efficient in risk assessing and managing individuals who behave in a harmfully sexual manner.[21]

Police Bail

6.3.5 Following the changes to Police pre-charge bail in April 2017, arising from the provisions in the Police and Crime Act 2017, it is unlikely that YPA would now be subject to any bail conditions. The Police view is that in all probability he would now be released under investigation, with no restrictions. The current bail arrangements therefore suggest that in cases like that of YPA, the Police would have limited powers to risk manage such individuals.

6.3.6 Therefore, in situations involving care leavers it is imperative that there is timely liaison between the Police, the NCSC/care leaver's service and other relevant agencies. Clearly, at the point of arrest the Police would not necessarily know that the individual was a care leaver. As per existing procedures, a referral would normally be made to the MASH resulting in a strategy discussion focused on safeguarding the child victim. The alleged perpetrator could be identified as a care leaver at the point of the strategy discussion and ensuing section 47 enquiry, following routine interrogation of agency databases.

6.3.7 Likewise, any decision not to hold a strategy discussion should be recorded, including the rationale.

Inter-agency information sharing

6.3.8 The communication between the Youth Training Agency and the Leaving Care team was poor with messages left by the former not being responded to by the latter.

6.3.9 Because of the non-availability of TM2 the review was not able to understand precisely why critical information about YPA's arrest, bail conditions and the ongoing police enquiry were not passed on to the District Housing Agency on the 20 May 2016. A likely reason was that TM2 may have had a poor understanding of the parameters of information sharing regarding YPA's conditional rights to confidentiality. Had information about YPA's bail conditions and the ongoing Police enquiry been shared with the Housing Agency, as it could have been, it is probable that YPA would not have been placed at the temporary accommodation where Child Z and his family were resident.

Inter-agency risk management; 9-24 June

6.3.10 The actions of the Police and NCS/Care Leavers' team to have the District Housing agency move YPA were ineffective due to a combination of the following factors:

[21] See sections 4.3.11-4.3.12 above and Appendix 2

- No personal adviser in place during May to mid-June to act as a co-ordinating single point of contact (SPOC) in the care leavers' team.
- Ineffective care leavers' team management oversight and involvement in the episode.
- A delay in allocating a new personal adviser (PA2) to the case.
- Inadequate briefing, direction and support given to PA2 on becoming the allocated personal adviser on the 20 June. PA2 was unaware of YPA's bail conditions.
- Deficient preparation, induction, learning and development given to the Leaving Care Team
- Poor safeguarding knowledge by the leaving care team.
- Staff shortages
- Misplaced understandings by the leaving care team around the parameters of inter-agency information sharing regarding YPA's bail conditions.
- Mistaken assumptions and misunderstandings by the Police and the Leaving Care team that the other was liaising with the District Housing team to move YPA, when this was not the case.

6.3.11 A timely strategy discussion and multi-agency risk management meeting could have been convened by the leaving care team when it had become evident on the 10 June that YPA was in breach of his bail conditions. Arguably, this could have been done under the NSCB HSB procedures, albeit that YPA was an adult but still a responsibility of the local authority.

Key Learning; See above at 6.1.15

For Norfolk Police/ Norfolk Children's Services regarding the CSE Perpetrator scheme

- For risk assessments to be translated by the multi-agency risk panel into effective risk management plans on suspected perpetrators
- Much of the learning from the above findings has been incorporated into the current operation of the CSE perpetrator scheme[22]. Of critical importance is the need to ensure that, when appropriate, risk assessments are passed on to the multi-agency risk panel for actioning.

For Norfolk Police regarding arrest and Police Bail

- See sections 6.3.5-6.3.7 above

[22] See previous note 22, ibid.

6.4 ToR 4

6.4.1 There was an appropriate and timely Police enquiry that led to the speedy arrest and subsequent charging of YPA.

6.4.2 As to why Child Z and his family did not receive an appropriate and timely Child in Need support service the following factors are relevant. Firstly, as identified at the Learning Event, there should have been a strategy discussion and joint S.47 Police/EDT/CSC enquiry in compliance with NSCB safeguarding procedures. This did not happen because, in the opinion of the lead reviewer, there was an overemphasis on processing the criminal enquiry. This was aggravated by it taking place at the weekend with a reduced service, when there was no MASH (NCS) service[23]; and insufficient focus on Child Z's medium/longer term well-being from the Police and Norfolk (MASH) CSC on the Monday morning.

6.4.3 Secondly, there are pressures on 'High volume, rapid throughput' services, such as MASHs to process demand (referrals) quickly, sometimes at the expense of keeping a focus on (in this case), the child.

6.4.4 Thirdly, there may have been some conflation between Child Sexual Abuse and Child Sexual Exploitation resulting in the outcome of a CSE risk assessment rather than understanding Child Z's experience as sexual abuse needing a strategy discussion, a S.47 joint enquiry and social work assessment of need by NCSC.

6.4.5 Fourthly, the EDT should have convened a strategy discussion, recorded it and let the MASH know of the outcome. This raises questions as to whether the Out of Hours/Weekend EDT/Police Countywide VPU interface presents as a potential weak point in the safeguarding process. Where a strategy discussion has been held at the weekend a second strategy discussion should be called for Monday mornings as standard practice to ensure health and other agency involvement, as appropriate.

<u>The Current Situation: Changes to the MASH service</u>

6.4.6 Since the incident, there have been several changes made to the operation of the MASH service which NCS report will make a difference to practice. Firstly, since the 17 May 2017 it is now standard practice for the Children Services MASH manager to review the Police Night Book before the 9am meeting thus enabling research to be undertaken on NCS's electronic systems. This should result in greater consideration being given to what action is needed to ensure the child's safety and welfare, rather, than in Child Z's case, just hearing the information shared at the 9am meeting.

6.4.7 Arguably, this highlights the importance of the imperative to keep a focus on both the safety and welfare of the child and to be aware of an over focus on technical

[23] Albeit, there was a Police MASH service.

processing. This is a good example of how interaction at the human/technical interface can result in a 'Tickbox', approach when human action is subsumed to the technology.

6.4.8 Secondly, work is in progress to improve the handover between EDT and the Children's Service element of the MASH, including, when appropriate, the requirement by EDT to convene and record strategy discussions and not to re-assign to the MASH or the allocated locality team to deal with later.

6.4.9 Thirdly, the links with the Early Help and Family Focus (EHFF) service within the MASH have been improved (see below). When a threshold decision is made that a social work assessment is not required the EHFF manager is asked to contact the referrer and family to see if an Early Help offer is appropriate.

Key Learning to consider

For the MASH and EDT:

- Ensure that in cases of extra-familial sexual abuse strategy discussions are appropriately convened and joint S.47 Police/EDT/CSC enquiries undertaken in compliance with NSCB safeguarding procedures.
- The need to maintain a focus on the child when processing a criminal enquiry.
- Ensure that there is a focus on the child's medium/longer term well-being from the Police and Norfolk (MASH) CSC on the Monday morning meetings.
- To bear in mind the pressures on 'High volume, rapid throughput' services, such as MASHs to process demand (referrals) quickly, sometimes at the expense of keeping a focus on the child.
- The need for awareness around possible conflation between Child Sexual Abuse and Child Sexual Exploitation resulting in the outcome of a CSE risk assessment rather than understanding the subject child's experience as sexual abuse needing a strategy discussion, a S.47 joint enquiry and social work assessment of need by NCS.
- Ensure EDT compliance with NSCB safeguarding procedures, including, when appropriate, the holding and recording of a strategy discussion with the Police (and/or other agencies) and passing it onto the MASH in a timely manner.
- Ensure that there is not a potential 'Weak spot' in the safeguarding process at the Out of Hours/weekend EDT/ Police interface.

For the SARC Board:

- Consider whether the remit of the SARC can be changed to include children and young people who have suffered non-penetrative sexual abuse.

6.5 Key Learning for the NSCB to consider

- That the HSB procedures are fit for purpose and up to date.
- That there is a robust strategy to disseminate and embed the HSB policies and procedures, including the need for early risk assessments and management plans

for children and young people identified as presenting HSB, across the safeguarding partnership that includes the Care Leaving Service, the MASH, and relevant sections of the Police service.

- That the findings and learning from this SCR will be widely disseminated and implemented across the NSCB partnership so as to make an evidenced and demonstrable improvement to the safeguarding outcomes for children and young people.

6.6 Six Overarching Lessons

Finally, many learning points have been identified by this SCR, all of which are commended to the NSCB and its partners. However, here are six overarching lessons:

1. Norfolk Children's Services should retain a focus on improvement to ensure its leaving care service is consistently fit for purpose.

2. The need for the NSCB and agencies to put in place effective early intervention services for the assessment, treatment and risk planning of young people, including care leavers, who exhibit harmful sexual behavior.

3. (a) Norfolk Children's services shall not, at any time, place unaccompanied children under 16 years of age in temporary accommodation.

   (b) Local housing authorities and their agents should not place 'households' with children under 16 years of age in non-self-contained (i.e. shared toilets/bathrooms/kitchens) temporary accommodation nor 'households' with children under 16 years of age in self-contained temporary accommodation with shared communal facilities (e.g. rest room/bar) unless there is no alternative solution available.

   (c) Local housing authorities shall demonstrate their adherence to this policy by retaining relevant statistics on TA and reporting to District Council Safeguarding Group as required.

4. Arrangements to be in place so that Police CSE Perpetrators' risk assessments result in effective and timely multi-agency planning of suspected individuals.

5. On the arrest of individuals for alleged extra-familial sexual offences against children, the Police should make a referral to Children's Services who will consider ongoing safeguarding risks to children and will arrange for a strategy discussion to be held, if appropriate. This will allow for consideration of a S.47 enquiry, safeguarding of the relevant children and, if applicable, the identification of the suspect as a care leaver.

6. The need for the care leavers' service to be familiar with the NSCB Information Sharing protocol, the limits of data protection and when it is necessary to override confidentiality in the interests of safeguarding vulnerable individuals.

Part 7
Recommendations

7.1 Norfolk Children's Services

7.1.1 The Director of Children's Services should within six months of the approval of this SCR take steps to assure the NSCB that the Leaving Care service continues to make progress to the point where it is rated as, 'Good', by Ofsted and achieves high quality outcomes for care leavers, by reference to the learning in Part 6.1.20 Key Learning above at page 27.

7.1.2 The Director of Children's Services should within six months of the approval of this SCR, take steps to assure the NSCB that a service is in place for early intervention regarding the assessment, treatment and risk planning of young people, including care leavers, who exhibit HSB.

7.2 Norfolk Housing Options

7.2.1 The Director of Housing Options, or their local District Council equivalent, should within six months of the approval of this SCR take steps to assure the NSCB that children under 16 who are in need of temporary accommodation are found placements which maximise their safety and well-being by reference to the learning points in Part 6.2.7 Key Learning above at page 28 and Overarching Lesson 3 (a) (b) (c) at page 35.

7.3 Norfolk Constabulary

7.3.1 The Chief Constable of Norfolk Constabulary should within six months of the approval of this SCR, take steps to assure the NSCB that, (a) the CSE Perpetrators' Scheme is operating effectively, (b) that a safeguarding referral is made to the Children's Services on arrest of an individual suspected of being a perpetrator in extra-familial sexual abuse of a child.

7.4 Jointly for Norfolk Children's Services and Norfolk Constabulary

7.4.1 The Director of Children's Services and the Chief Constable should within six months of the approval of this SCR, take steps to assure the NSCB that, in cases of extra-familial child sexual abuse, arrangements (when appropriate) are made by the Children's Services to convene strategy meetings and initiate joint S.47 CSC/Police/EDT enquiries, in compliance with NSCB safeguarding procedures, by reference to the learning points in 6.4.9 Key Learning above.

7.5 For the SARC Board

7.5.1 The SARC Governance Board should report to the NSCB on the feasibility of expanding the service remit to include children and young people who have suffered non-penetrative sexual abuse.

7.5.2 For the Health and Voluntary sector to advise the NSCB on any services outside of the SARC that can provide support to children and young people who have been sexually abused so that the Board can promote these services and address any commissioning gaps.

7.6 Norfolk Safeguarding Children Board

7.6.1 That the NSCB Chair should within six months of the approval of this SCR, take action to ensure that:

- The HSB procedures are fit for purpose and up to date.
- That there is a robust strategy to disseminate and embed the HSB policies and procedures, including the need for early risk assessments and management plans for children and young people identified as presenting HSB, across the safeguarding partnership that includes the Care Leaving Service, the MASH, and relevant sections of the Police service.
- That the findings and learning from this SCR will be widely disseminated and implemented across the NSCB partnership so as to make an evidenced and demonstrable improvement to the safeguarding outcomes for children and young people.

Glossary of Terms

ABE	Achieving Best Evidence
ADHD	Attention Deficit Hyperactivity Disorder
AIM2	Adolescent Integrated Assessment Model
CARF	Child Assessment Referral Form
CSE	Child Sexual Exploitation
CSW	Children Services Worker
CPS	Crown Prosecution Service
DfE	Department for Education
EDT	Emergency Duty Team
EET	Education, Employment and Training
HMO	Home with Multiple Occupation
HSB	Harmful Sexual Behavior
IRO	Independent Reviewing Officer
KLOE	Key Line of Enquiry
LAC	Looked after Child
MASE	Multi-Agency Sexual Exploitation team
MASH	Multi-Agency Safeguarding Hub
NCS	Norfolk Children's Services (Local Authority)
NCSC	Norfolk Children's Social Care (Local Authority)
NEHFF	Norfolk Early Help and Family Focus
NSPCC	National Society for the Prevention of Cruelty to Children
NSCB	Norfolk Safeguarding Children Board
NVQ	National Vocational Qualification
Ofsted	Office for Standards in Education
SW	Social worker
PA	Personal adviser (Care leavers' service)
PO	Police Officer
Psy1	Psychologist 1
SARC	Sexual Assault Referral Centre
SCR	Serious Case Review
TM	Team Manager
ToR	Terms of Reference

References

1. Harmful Sexual Behavior; NSPCC, Research in Practice, Durham University, 2016

2. Norfolk Child Sexual Exploitation Perpetrators Risk Assessment, V1, 29.01.16, Norfolk Constabulary

3. Norfolk Safeguarding Children Board, Safeguarding Procedures online

4. Norfolk Children's Services, Looked after Children and Care Leavers' Strategy, 2016-19.

5. Working Together, 2015, H.M. Government

6. Ofsted Report on Inspection of Norfolk Children's Services, November 2017, published 19 January 2018.

Appendix 1

Timeline of Significant Events

Month	Year	Event
November	2011	YPA moves to Residential Home
January	2013	YPA reaches his 16th birthday
July	2013	Risk assessment of YPA completed by Children's Services
September	2013	Psychological risk assessment of YPA's HSB completed
September	2013	YPA starts course at College
April	2014	Investigation by Children's Services on YPA
June	2014	MASH referral on Child X
August	2014	Meeting convened by Residential Home agency and psychologist on YPA's HSB
August	2014	MASH referral on Child Z
January March	2015	YPA now 18: care leaver YPA moves into semi-independent flat provided by Residential Home agency
May	2015	YPA moves out of the semi-independent flat provided by the Residential Home agency into shared accommodation
November	2015	Child Z's family homeless
December	2015	Strategy discussion held on YPA's sister and friend and risks posed by YPA
December	2015	YPA arrested and bailed for sexual assault on Child B. Children's Services informed
January	2016	YPA family move to temporary accommodation
Feb – April April	2016	YPA 'sofa surfing' and looking for accommodation Police assess YPA as a ' Medium Risk' of CSE
Early May	2016	YPA contacts social work team – homeless, needs somewhere to live
Mid May	2016	YPA presents at local DC office. Housing Options make contact with leaving care team re YPA's homelessness
24 May	2016	YPA moves into temporary accommodation

10 June	2016	Police and Children's Services discussion re moving YPA from temporary accommodation due to bail conditions
14 June 10-24 June	2016	Police conduct CSE perpetrator review Leaving Care team and Police botched attempt to move YPA
16 – 19 June	2016	Child Z sexually assaulted by YPA
24 June	2016	District Housing informed by leaving care team of YPA's bail conditions and decision made to move him. Incident reported to police by Child Z's mother YPA arrested
26 June	2016	Local DC state they were not aware of YPA's previous bail conditions
27 June	2016	CSE screening on Child Z. Given standard risk. Referred to Early Help
28 June – 2 July	2016	YPA charged with sexual offences against Child Z and Child B [Dec 2015]

Appendix 2

Part 2

Aims and Terms of Reference of the SCR

2.1 Aims

The overall purpose of this Review is set out in Government Guidance[24], namely to undertake a rigorous, objective analysis that will:

- "Look at what happened in this case, and why, and what action needs to be taken to learn from the Review findings.
- Action results in the lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.
- There is transparency about the issues arising from this case and actions which the organisations are taking in response to them.
- Including sharing the overview report with the public"

(Working Together: 2015, 72)

2.2 Terms of Reference (ToR)

The SCR and overview report have been undertaken in relation to the following Terms of Reference, namely:

(A) Critically examine the effectiveness, or otherwise, of the care leaver planning for Young Person A (YPA). How well did the plan meet his needs for transition to independent living and address issues of risk assessment and management of his sexually harmful behaviour?

(B) How well were the needs, vulnerabilities and risks to Child Z and his family assessed and managed by agencies during the time they were homeless and in temporary accommodation?

(C) Critically evaluate the efficacy, or otherwise, of inter-agency working, decision making and information sharing regarding the safeguarding of Child Z whilst in temporary accommodation. How child focused were multi-agency safeguarding actions (including Police bail management) and did they comply with existing local inter-agency safeguarding policies and procedures?

(D) Why did Child Z and his family not receive the appropriate multi-agency support services and Early Help offer, following the sexual abuse?

[24] Working Together to Safeguard Children (2015): HM Government/Department for Education

2.3 Scope of the Review

The SCR examined in depth the decisions and actions taken by agencies and the significant events occurring between January 2013, when YPA turned 16 and November 2016, the commission date of this review.

2.4 Methodology

The SCR was undertaken by;

- Reference to the four ToRs.
- Collating a composite chronology within the above time-frame of the five agencies' involvement with Child Z, his family and YPA.
- Receiving reports from the five agencies[25] informed by the ToRs and the KLOEs.
- Sight of all relevant documents.
- Reflective conversations between the lead reviewer and key front-line professionals.
- A conversation with the mother of Child Z
- A conversation with YPA
- Conversations with professionals involved with the case.
- Discussion and analysis of the case at five overview Panel meetings
- The holding of a Practitioners' Learning Event on the 13 June 2017, facilitated by the lead reviewer and SCR Chair and underpinned by five Key Practice Episodes.
- The adoption of a broadly, 'Systemic', approach to the understanding and analysis of how and why YPA was able to sexually assault Child Z within an organisational context of professionals' actions and decision making at the time.
- A focus on learning and not second guessing with the benefit of hindsight.

2.5 The Overview Panel

The Overview Panel consisted of the following senior agency representatives:

Detective Inspector	Norfolk Constabulary
Designated Nurse for LAC	Great Yarmouth & Waveney CCG
Designated Nurse, Safeguarding Children	Great Yarmouth & Waveney CCG
Education Adviser for Schools	Norfolk County Council-Education
Head of Environmental Health Housing Options	Local District County Council
Family Intervention Team Manager	Norfolk Children's Services

[25] Norfolk Constabulary, Norfolk Children's Social Care, Local District Council/Housing Options, Norfolk Community Health and Care, Norfolk Education

Deputy Named Nurse, Safeguarding	Norfolk Community Health & Care
Chair	Norfolk Children Safeguarding Board Business Manager

2.6 Lead Reviewer

Mr Paul Sharkey (MPA)[26] was the lead reviewer. He had no previous connection with either the NSCB or any of the partner agencies, including those involved in the SCR. He has written and/or chaired more than fifteen SCR reports since 2002 and has attended several DfE/NSPCC courses on improving the quality of SCRs over the last few years.

2.7 Confidentiality

In compliance with Government guidance this SCR has respected the right to anonymity of Child Z and his family, YPA and the professionals involved in the case.

2.8 Family Involvement

The views of Child Z mother (MZ) were noted in a conversation with the lead reviewer and the Chair. Child Z choose not to talk to the lead reviewer.

2.9 Race, religion, language and culture

Child Z and his family are of White British heritage whose language is English. The family's religion, if any, is not known.

2.10 Parallel Enquiries

There are no other outstanding enquiries. The criminal proceedings regarding YPA were concluded in May 2017 when he was convicted of various sexual offences against Child Z and another child and given a custodial sentence.

2.11 Dissemination of Learning

The NSCB will disseminate the learning from this SCR by:

- Ratifying the report at Board
- Publishing the report on the NSCB website alongside a summary Power Point of key learning for dissemination within agencies and teams

[26] Master in Public Administration (2007) from Warwick University Business School; Certificate in Strategic Management; Kennedy School of Government, Harvard University.

- Incorporating the learning in the implementation plan for the NSCB Strategy on Preventing, Identifying and Tackling Child Sexual Abuse
- Incorporating the findings, recommendations and actions in the NSCB's Composite Action Plan and the Thematic Learning Framework
- Ensuring that all the Board's subgroups, including the sector specific Advisory Groups, the Local Safeguarding Children's Groups and the Workforce Development Group, are aware of learning and single/multi-agency actions required to take learning forward
- Undertaking a series of multi-agency roadshows to disseminate learning from this and other SCRs

The above will also be followed up in the Section 11 safeguarding self-assessment challenge days.

Appendix 3

Norfolk Police CSE Perpetrators' Scheme

1. If a young person aged under 18 who is living in Norfolk is deemed as a CSE perpetrator and a Police investigation has not resulted in conviction, but there are ongoing concerns around harmful sexual behaviour the Police will request a consultation with The Harmful Sexual Behaviour Team. This consultation service will provide advice on identifying areas of concern around harmful sexual behaviour, developing an understanding of the young person's needs, safety planning and identifying resources/interventions to use with the young person.

2. During the CSE perpetrator risk assessment process research will be conducted on the Children's Services Carefirst system to identify if they are open to Children's Services or gain details of any previous engagement. Further to this, the Police will assess their home life as part of any overt visit conducted to the CSE Perpetrator; a visit is not always conducted to a CSE perpetrator, when, for example, they are already under investigation for the offence for which they have been referred to the CSE Perpetrator Scheme.

3. The CSE Perpetrator SPOC (single point of contact) has attempted to liaise with YOT in order to integrate their involvement at an early stage, in particular during risk assessment and to establish a two-way intelligence stream between both organisations as the perpetrator work progresses.

4. The CSE Perpetrator Scheme liaises with the NPS (Norfolk Police Service) in order to employ disruption tactics and safeguarding measures with those offenders open to the NPS who have an ongoing concerning association with a young person. For example, the MASE Team will request regular visits to the offender and if offences are identified, will look to pursue recalls or breaches of supervision licences in order to disrupt the relationship. Further to this, the MASE Team will request CSE focused exclusion and non-association conditions to release licences once offenders are released again following the recall.