Gloucestershire
Safeguarding Children
Executive

Lauren

Serious Case Review

Jane Wiffin July 2020

1. Introduction

Reason for the Review

1.1 This Serious Case Review[1] is about Lauren[2] who is now aged 18. When she was 17, she came into foster care through an Emergency Protection Order (EPO[3]). The trigger event for the EPO was Lauren (aged 17) being sexually exploited and harassed on-line by an adult male who had asked her to meet him where he would give her money and alcohol to engage in sexual activity. There had been a long history of Lauren being sexually abused, raped and exploited by predatory men. Lauren had expressed a wish to die on social media and there were concerns about her father being able to protect her. An Emergency Protection Order was sought and granted; Lauren was placed in foster care.

1.2 A children's guardian[4] was allocated for the follow up hearing to extend the EPO; she reviewed the chronology provided by Gloucestershire Children's Social Care (GCSC) about their involvement with Lauren and her family dating back to February 2016, when Lauren was 14. This contained information about 149 significant events, including allegations of sexual assault, sexual exploitation and rape. Lauren had been provided with services under a child in need plan for a year and was subject to child protection plans under the category of neglect for 2 years. During this time, she was assessed as having significant learning disabilities, poor health, emotional distress and a Mental Capacity Assessment in early 2018 had found that she did not have the capacity to consent to sexual activity. From January 2018 onwards there were a number of Legal Planning meetings to consider whether the threshold for issuing legal proceedings had been met; these were beset by delay, drift and incident led practice. At the beginning of 2019 there were escalating concerns about the extent of the sexual abuse and sexual exploitation that Lauren experienced and growing evidence that her father and sister had facilitated her meeting inappropriate adults. Lauren was nearly 18 when the EPO was taken, and so proceedings continued under

[1] A serious case review (SCR0 was the process undertaken after a child died or was seriously injured and abuse or neglect was thought to be involved. Its purpose was to look at lessons learnt to help prevent similar incidents from happening in the future. The arrangement for undertaking reviews of critical incidents relating to children and young people has changed and serious case reviews are no longer undertaken. They have been replaced by child safeguarding practice reviews; CSPR.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[2] An anonymised name

[3] An Emergency Protection Order (EPO) enables a child to be removed from where s/he is, or to be kept where s/he is, if this is necessary to provide immediate short-term protection. Under Section 44 of the Children Act 1989, the local authority (or any person) can apply to the family court for an Emergency Protection Order where: The court is satisfied that there is reasonable cause to believe that the child is likely to suffer Significant Harm if s/he is Not removed to accommodation provided by the applicant;

[4] A Children's Guardians is qualified and experienced social work who is appointed by the court to represent the rights and interests of children in care proceedings. Their role is to consider what is best for the child at all times during a case

the auspices of the court of protection. She remains protected and living away from home.

1.3 The Independent Chair of Gloucestershire Local Safeguarding Children Board agreed that Lauren had experienced significant harm, despite extensive safeguarding activity, and therefore the criteria for an SCR had been met.

Process of the Review

1.4 The approach to this review is consistent with the principles and approach set out in Working Together 2015[i]. An independent overview author (Jane Wiffin) was commissioned to lead the review and write this overview report. A multi-agency panel was convened to oversee the SCR, contribute to the analysis and provide critical feedback on the report. Each agency involved with Lauren and her family were asked to complete individual chronologies, an appraisal of their agency's response and to make single agency recommendations to address any practice concerns or to promote effective practice. These documents were discussed at meetings of the multi-agency panel and further amendments made as a result. The author used these documents and some original records as the basis of her understanding of the professional response to Lauren. Each agency interviewed its own staff and an event was held to bring all those who had worked with Lauren and her family together to contribute to the analysis and lessons to be learned. Their contribution was invaluable and the author and panel would like to thank them for what was a difficult task. The author is responsible for the completion of this report.

Lauren and her family

1.5 Lauren and her family are white/British. She has one sister who is 3 years older than her; Jem[5]. Both girls were brought up by their mother and father in complex circumstances (see section 2). When Lauren was 11 and Jem 14, their mother took them to live in another local authority area. They remained there for 9 months, but moved back to Gloucestershire to live with their father where they remained with him until Lauren was removed from his care in 2019; he had a partner, who did not play a parental role in Lauren's life. Lauren and Jem continued to visit their mother and they were in regular contact. Lauren has a paternal grandmother who lived close to her and who she saw regularly. There is no information about any other extended family. A family group conference was held in 2016, but no extended family attended. This is the only evidence that the role of the extended family was explored.

[5] An anonymised name

Lauren's Involvement

1.6 Lauren has been settling into foster care whilst this review was ongoing. This was an unsettling time for her and although she is doing very well, it was felt that to meet another new adult, the author, would be unsettling and impact on her placement stability. Her social worker has spoken to her about her feelings about the last few years and has shared these with the author. This information is woven into the fabric of the report.

Family Involvement

1.7 Given that Lauren could not be spoken to directly, and this report is about her, it did not seem right, given the complex circumstances, to speak to either parent or the sister. There also remain issues about Lauren's future to be resolved which take priority.

2. Background History

Lauren's Early Life: a brief summary

2.1 Lauren has had contact with many different specialist services throughout her childhood due to issues of neglect caused by her parents own difficulties. The poor physical and emotional care provided to Lauren resulted in global developmental delay and specific concerns about her impaired gross motor skills. Lauren was slow to walk, with professionals attributing this to being strapped into a pushchair for long periods of time. This also led to lifelong mobility issues which required regular hospital attendance. These early developmental impairments would remain as areas of health and education concerns which impacted on her throughout her childhood.

2.2 When Lauren was aged 3 and Jem aged 5 the nursery/school they attended had worries about Jem's knowledge of sexual matters which they assessed as inappropriate for her age. They made a referral to GCSC and assessments and support were provided.

2.3 Over the next four years there were a number of referrals from different agencies to GCSC, an early help assessment (called a Common Assessment Framework[6]) was completed and support provided; this early help plan progressed into a Child in Need (CiN) plan[7] because of increasing concerns about safety and well-being. The lack of progress of the CiN plan led to Lauren (aged 7) and Jem (aged 10) becoming subject to Child Protection (CP) plans[8] for neglect for a period of 6 months; a pattern that would be replicated later in their lives. Although there remained concerns about parental conflict and ongoing neglect, the CP plan was discontinued and support again provided through a CiN plan for a further period of 9 months. This ceased and Lauren and Jem attended school, but were not in contact with any specialist support services.

2.4 When Lauren was 10 and Jem 13 their mother withdrew them from school to home educate them. The school were concerned and an assessment completed; this concluded that mother should ensure that Lauren and Jem returned to school immediately. Mother then moved to another local authority area taking the girls with her and contact with Gloucestershire services ceased. The girls remained out of school for the next 9 months.

[6] The Common Assessment Framework (CAF) was the process to identify children who have additional needs, assess needs and strengths and to provide them with a co-ordinated, multi-agency support plan to meet those needs. Every Child Matters and The Children Act 2004

[7] Children in need are defined in law as children who are aged under 18 and: need local authority services to achieve or maintain a reasonable standard of health or development. need local authority services to prevent significant or further harm to health or development. are disabled. A CIN Plan is drawn up following a Single Assessment which identifies the child as having complex needs and where a coordinated response is needed in order that the child's needs can be met.

[8] A child protection plan is drawn up at the initial child protection conference. It says what support and monitoring will be put in place when a child is considered to be at risk of significant harm because they have suffered, or are likely to suffer physical abuse, emotional abuse or sexual abuse or neglected.

2.5 Mother then told the girls' father she could not cope because of Lauren and Jem's behavioural problems and they returned to live in Gloucestershire with him in 2013. There was initial contact with GCSC and the Police with the focus being on how to manage appropriate contact with mother. Lauren and Jem started to attend school in the final term of the year; Lauren in year 7 and Jem year 10. They would both remain at this school for the rest of their school career; leaving at age 16. They seemed to settle in, though Lauren was subject to bullying; this appears to have been caused by pupil attitudes to her difficulties with walking caused by earlier neglect. She was noted to have a learning disability and was provided with special educational needs support. At this stage there was no clear outline of her specific learning needs or the extent of her cognitive difficulties.

2.6 At the beginning of year 8, when Lauren was aged 11 and Jem aged 14, the school were concerned about their low attendance and poor emotional wellbeing said to be caused by contact with their mother. Support was provided by the Families First Team[9] for the next 6 months. The school remained concerned about Lauren, reporting that she was displaying heightened anxiety and stress due to complex and fractious family relationships. The school made their first referral to GCSC. A single assessment[10] was completed which focussed on mother and both girls contact with her. Concerns about Lauren self-harming were highlighted, but no proposal for how this might be addressed. GCSC decided there was no role for them and work continued with Families First Team to provide support to father about how to ensure Lauren and Jem had safe and appropriate contact with mother. Jem was referred to Children and Adolescent Mental Health Services (CAMHS[11] - previously known as CYPS in Gloucestershire) at this point by her GP because of concerns about her low mood and self-harm. This referral was not accepted.

[9] Families First is a family support service provided by the local authority which aims to help families within a 6-12-week review cycle in order to make and sustain improvements. They use a 'whole family approach' which involves identifying the things that are impacting on the family environment and using the family's strengths to build stronger family units.

[10] A Child and Family (C&F) Assessment addresses the most important aspects of the needs of a child / young person, and the capacity of his or her parents or care givers to respond appropriately to these needs within the wider family and community context. The conclusion of the assessment should provide analysis of the findings leading to a clear understanding of need that will facilitate care planning and inform service provision. C&F Assessments should contain input from other professionals.

[11] CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are the NHS services that assesses and treat young people with emotional, behavioural or mental health difficulties.

3. Chronology of professional involvement: November 2015 to March 2019

This review is about the significant sexual exploitation, sexual assault and sexual abuse of Lauren by predatory men who were aged from teenagers to much older men. The chronology will not provide much detail about this ongoing sexual abuse because this is private to Lauren.

It is important to say that the level of the sexual abuse and exploitation was serious, causing significant harm, was exacerbated by her known medical needs, and was frequent. The language used in the records by many professionals during this time was that Lauren was making active choices, putting herself at risk, actively sexualised and at times seeking out the abusers. This language does not accurately reflect the level of exploitation and grooming that she experienced by predatory males, the lack of protection or guidance from her father who appears to have encouraged Lauren, or the realities of her cognitive capacity to make informed choice. Therefore, the language has been changed by the author in the summary chronology that follows to make it clear that it is the responsibility of the predatory men who cajoled, groomed and exploited Lauren and this will be discussed in the findings that follow the chronology.

There were many professionals and services involved with Lauren over the 3 years and 3 months under review. This means it is impossible to outline all contacts and actions by those professionals; the chronology focusses on significant events and episodes. What is clear is that many professionals worked very hard on Lauren's behalf and were very worried about her safety and well-being.

Early Concerns: November 2015

Lauren is aged 14

3.1 The initial scoping for this SCR set the period from March 2016; there were earlier concerns about sexual exploitation and it seemed important to start at this point.

3.2 In November 2015 pupils reported concerns to school staff about posts on Facebook indicating sexual exploitation and likely sexual activity relating to Lauren aged then 14. This was reported to GCSC. There was no response and school escalated their concerns to the Gloucestershire Safeguarding Children Board office (GSCB). A strategy meeting[12] was held on 2nd December and possibly there was a follow up meeting on the 8th December. Given these allegations related to a child of 14 years old it would have been expected that a single assessment or Child Protection

[12] This is a meeting or discussion which takes place between Children's Services, the Police and possibly other child care agencies at the beginning of child protection enquiries. The purpose of the discussion is to decide whether and how the child protection enquiries should be carried out; and whether any immediate steps need to be taken to keep the child safe while the child protection investigation is underway, for example, if someone should be asked not to have contact with the child for the time being.

inquiry[13] would have been initiated. This should have included talking to Lauren about if anything harmful had happened to her. The decision was that the work with Families First Family Support Worker (FSW) would continue.

3.3 In February 2016 the school were concerned about reports that Lauren was being uncharacteristically aggressive and when this was discussed with her, Lauren reported to her teaching assistant that her father was rarely at home and left Jem to look after her with her new boyfriend about whom there were concerns that he posed a sexual threat to children. Lauren was 14 and Jem 16. Lauren said she had witnessed sexual activity and sexual discussion between her father and his girlfriend and Jem and her boyfriend. Lauren also reported that her father had threatened to physically beat her because of what she had seen. This information was shared with the Families First FSW and it was agreed this would be shared with GCSC.

3.4 Over the next few weeks further information of concern emerged. Lauren was sent sexually explicit photos. She had attended a party at her mother's where there was excessive alcohol use; Jem reported that Lauren was seen in the company of a man in his mid-twenties and she was concerned. There was confusion about what action was being taken. The Police were involved and school contacted GCSC. It was agreed that a strategy meeting would be convened and this took place 6 weeks after the original concerns and at this meeting it was agreed that child protection inquiries would be undertaken.

3.5 Two days after the strategy meeting Lauren told school that she had been raped whilst visiting her mother for a Halloween party in 2015; this was in the context of a party where everyone including Lauren was consuming large amounts of alcohol. A Police inquiry was started and this did not conclude until October 2018. Child Protection inquiries were already underway and no further strategy meeting was convened regarding the allegation of rape. Lauren was seen by her GP who made a referral to the Sexual Assault and Referral Centre (SARC[14]) for sexual health support; Lauren was provided with an Independent Sexual Violence Advisor (ISVA[15]) outreach worker to support her through the Police investigation and potential trial and to be a single point of contact for Lauren.

[13] Children's Services have a legal duty to look into a child's situation if they have information that a child may be at risk of significant harm. This is called a child protection enquiry or investigation. Sometimes it is called a "Section 47 investigation" after the section of the Children Act 1989 which sets out this duty.
The purpose of the enquires is to gather information about the child and their family so that social workers can decide what action, if any, they need to take to keep a child safe and promote their welfare.

[14] Sexual assault referral centres (SARC) provide medical, practical and emotional support. They have specially trained doctors, nurses and support workers.

[15] Independent Sexual Violence Advisors (ISVAs) are trained to provide emotional and practical support to survivors of rape, sexual abuse and sexual assault. Their main role is to support around the criminal justice process, but they are independent from the Police and are not legal advisors.

Child in need process: April 2016 to April 2017.

3.6 There were ongoing concerns about sexual exploitation and Lauren talked to the school nurse about her worries. The GCSC single assessment was completed at the end of April and this highlighted:

- that Lauren was at significant risk of sexual exploitation and online grooming; the language from this point onwards was always about the likely risk, yet if people took seriously her allegations of rape she had already been significantly harmed and was at risk of more sexual harm. This does not come across clearly throughout the whole period of the review;
- there were concerns about the suitability of Jem's boyfriend because he was convicted of sexual offences against children, and Jem's risk of sexual exploitation;
- concern about Lauren's self-harm and her struggle to regulate her emotions;
- concerns about father's emotional unavailability, commitment to parenting and his ability to protect Lauren and Jem.

The issues about poor sexual boundaries in the home do not appear to have been discussed within the assessment, nor the implications for keeping Lauren or Jem safe from sexual harm. There is no sense that Lauren's learning disability was considered or the implications of this for the type of support she would need. The alleged rape was referred to as "non-consensual sex" and there was no plan of support included. The emphasis was on Lauren learning to keep herself safe and avoiding taking risks; essentially putting her safety on her own shoulders.

3.7 The conclusion of the single assessment was that Lauren and Jem would be supported through a CiN plan and that an Initial Child Protection Conference (ICPC[16]) might be convened in the future. This decision was inconsistent with the evidence of significant harm. The assessment does not draw on the knowledge or concerns of other professionals involved with Lauren at this point:

- School were worried about Lauren's safety and well-being as well as her engagement with learning; they extended the Special Educational Needs (SEN) support that she was provided with and asked that an Education, Health and Care Plan (EHCP[17]) be started. As part of this a cognitive assessment from a clinical psychologist had been commissioned;

[16] This is a meeting which takes place between social workers, other professionals and family members when a child is considered to be at risk of significant harm because they have suffered physical abuse, emotional abuse, sexual abuse or neglected. The conference meets to discuss the risk to the child and decide whether the child needs a child protection plan to protect him or her from harm in the future.

[17] This is a statutory document. An EHC plan details the education, health and care support that is to be provided to a child or young person who has a Special Educational Need or a Disability (SEND). It is drawn up by the local authority after an EHC needs assessment of the child or young person, in consultation with relevant partner agencies, parents and the child or young person themselves

- The GP was concerned about Lauren's emotional well-being and made referral to CAMHS. Lauren was offered an appointment and assessed as having no mental health concerns so no services required; a referral to Youth Support Team (YST) was proposed
- The School Nurse had completed a family needs assessment and was concerned about Lauren's mobility issues and made a referral to the physiotherapy team; Lauren had a malformation of her hip. The School Nurse continued to offer support through the School Nurse drop in which Lauren attended regularly; the School Nurse was concerned about issues of neglect and particularly ongoing head lice infestation which were untreated and Lauren's rotten teeth;
- Community Paediatrician 2 continued to see Lauren and had organised further tests regarding her physical wellbeing and physical circumstances;
- The SARC were supporting Lauren and her sexual health and well-being;
- The Police were investigating the recent allegation of rape and Lauren was provided with support regarding the criminal proceedings by an ISVA outreach worker;
- Families First/FSW1 were still offering support but they were concerned about father's poor engagement.

3.8 A draft CiN[18] plan was included in the completed single assessment which focussed on the risk of sexual exploitation for both girls, the need to consider whether father could protect Lauren and Jem, action to address hygiene and health needs including the lack of dental care and action to address Lauren's' deteriorating behaviour. This draft plan was not formulated into an actual CiN plan by the new social worker (SW2) and in reality, there was no plan or coordinated support for the next 12 months. The first CiN meeting took place at the end of April 2016. There was no CIN plan or goals and minutes were not taken. There was a delay in Social Worker (SW)2 visiting Lauren and the family and no action seems to have been taken until the end of the summer holidays. Lauren and her father talked about feeling unsupported by their SW.

3.9 At the end of June 2016 the cognitive assessment of Lauren was completed after Lauren had not been brought to a number of appointments. The clinical psychologist (who had assessed Lauren as a younger child) found she had very low-level basic literacy and numeracy skills, considerable difficulties with reasoning, problem solving, working memory and the ability to hold onto information. This assessment

[18] When a single assessment finds that a child is not at risk but is in need of social work services, a child in need plan involving other agencies involved with the family should be developed and agreed with the child's parents at a child in need planning meeting. The plan should set out what is working well within the family as well as any concerns, and be clear about which agencies will provide which services to the child and family. The plan should describe clear outcomes for the child and what is expected of the parents and how the plan will be reviewed.

informed a plan of action at school; it was shared with other professionals and should have informed the child in need process and all other agencies working with Lauren. This did not happen, and the individual support provided over the subsequent years did not always take account of Lauren's cognitive capacity; the work of the FSW and the youth worker being an exception.

3.10 In July 2016 school were aware of the summer holidays starting and expressed concern to GCSC that there had been little action to address the risks to Lauren, that she continued to be subject to sexual exploitation, was struggling to contain her emotions characterised by difficult and aggressive behaviour and was barely in school. SW2 replied and said that she had not been able to meet with the family as there had been no one at home on a number of occasions, that Families First were still involved, another family support worker had been allocated and it had been agreed by the GCSC managers that there was no need for ongoing social work support. SW 2 said that there was to be a CiN meeting[19] planned for two days later, but this did not take place, and was rescheduled to September.

3.11 School discussed this with the ISVA who made a safeguarding referral to GCSC; this was not responded to. The school nurse also sought information about the date of the next child in need meeting and what action was being taken to keep Lauren safe over the holidays; it was agreed that a joint visit between the social worker and school nurse would take place over the summer. School continued to share their concerns, requested a strategy meeting and this was agreed by GCSC; it did not take place. SW 2 and the School Nurse visited Lauren over the summer, but there is no case record of this within GCSC. SW2 made a referral to Youth Support Team and the young carers' project.

3.12 The CiN meeting planned for mid-September took place. There was still no CiN plan and the minutes consisted of four bullet points in GCSC case records. Soon after this meeting, father told school that he could no longer cope with Lauren's difficult behaviour and aggression and she had gone to live with her mother. All agencies were informed. Lauren returned to father's home at the end of September. Lauren's GP made a further referral to CAMHS and consultation was provided by CAMHS to the school and SW2 regarding Lauren's behaviour. Father had shifted the focus from his parenting to Lauren having problems with her behaviour. This was not challenged. The Youth Support Worker (YSW) (1) started seeing Lauren individually; Lauren said she would like to focus on self-harm, healthy relationships and support regarding the sexual abuse she had experienced. The GCSC single assessment was updated at the end of September. Much of the information was taken from the previous assessment and there was no analysis of the current circumstances for

[19] This is a regular meeting attended by all involved professionals, the family and child to discuss the progress of the child in need plan.

Lauren and no CiN plan formulated. This assessment was approved by the team manager for SW2.

3.13 During October 2016 there were increasing concerns about Lauren being targeted by predatory males for sexual exploitation on line, Lauren was sexually assaulted and a Police investigation started. Lauren also then reported that she and a friend were provided with tobacco and drugs including cocaine in exchange for sexual activity. These incidents were reported to the Police, but Lauren said she did not want to be interviewed or make a complaint. This should have been addressed sensitively by SW2.

3.14 At this time Lauren, who was now aged 15, told professionals that she had a boyfriend with whom she was involved in a sexual relationship; SW2 took her for contraceptive advice. There was an unquestioning acceptance of the concept of boyfriends over time (because Lauren described them as such) rather than a predatory male, without scrutiny or analysis, except by community paediatrician 2. A professionals' meeting was held, described by some agencies as a strategy meeting, to discuss ongoing concerns about sexual exploitation. There are no recorded decisions about next steps emerging from this meeting. There was also a child in need meeting; there was still no formal plan and the minutes consisted of brief notes.

3.15 In October 2016 SW2 made a referral to the diversion from care team[20] because it was believed that father was not coping with Lauren's behaviour and angry outbursts. The aim of this work was to support the whole family and to prevent family breakdown. The second allocated Family Support Worker (FSW2) noticed immediately that Lauren had significant learning needs; she didn't understand time, whether an event was a week ago, or 3 days ago or a month ago. She could not understand money, and she didn't know how to wash her hair or what to use to wash herself with. There were incidents of poor home safety, with Lauren having set fire to her hair which FSW 2 addressed in the short term. FSW2 focussed on improving these self-care skills; but there was no discussion about this lack of skills being connected to historic and likely ongoing neglect. FSW2 also offered father support through attendance at a parenting class, which he declined. He described himself as a "reluctant parent", a phrase that was used in many contexts and reports, but without an analysis of the meaning or implications for Lauren and Jem. FSW2 was concerned that father showed little concern about the sexual exploitation of Lauren.

[20] This was a specialist family support service intended to prevent family breakdown, caused largely by parenting difficulties in the context of adolescence.

3.16 In November the GP completed Lauren's learning disabilities review[21]. It is unclear the extent to which this was shared/discussed with other professionals and it did not influence the CiN process.

3.17 SW2 was unable to attend the CiN meeting in mid-November. Professionals expressed significant concerns about Lauren's lack of protection from sexual abuse and exploitation, her poor school attendance and ongoing evidence of her poor emotional and physical wellbeing. The clinical psychologist agreed to contact GCSC to share these concerns; the school also contacted the GSCB. The Police were also contacted by health services (unspecified which health agency this was) regarding Lauren and sexual exploitation. It was agreed that the senior practitioner and Police officer from the specialist Child Sexual Exploitation (CSE) team would become involved. SW2 deputy team manager (DTM) asked for a strategy meeting to be convened; this did not happen. The Police also chased the need for this meeting without success.

3.18 At the beginning of December 2016, school sought information from GCSC about why the agreed strategy meeting had not taken place without any reply. At this time father reported to the Police that Lauren had gone missing with unknown adult males. She was recorded as a missing person. Over the next week Lauren disclosed rape and sexual exploitation/assault by a number of men. A Police investigation started and a strategy meeting was held. This meeting was attended by FSW/SW2 and the Police. There were no representatives from health or education invited. It was agreed at this meeting that Child Protection inquiries[22] would be started and completed within a week and legal advice would be sought by GCSC. The subsequent strategy meeting discussed Lauren's cognitive difficulties, but no plan of action was agreed and the implications for the Police inquires and interviews were not addressed. Lauren's poor attendance at school was discussed and a possible referral to hospital education was considered.

3.19 The Police deleted applications on Lauren's phone. Lauren was reluctant to be interviewed about the rape and assault, but eventually agreed. At this Achieving Best Evidence (ABE[23]) interview she made a number of further disclosures about sexual

[21] Adults and young people (aged over 14) with a learning disability are offered annual health checks by the GP. This is because of concerns that this group of adults/YP often have poor physical and mental health. https://www.nhs.uk/conditions/learning-disabilities/annual-health-checks/

[22] Children's Services have a legal duty to look into a child's situation if they have information that a child may be at risk of significant harm. This is called a child protection enquiry or investigation. Sometimes it is called a "Section 47 investigation" after the section of the Children Act 1989 which sets out this duty. The purpose of the enquires is to gather information about the child and their family so that social workers can decide what action, if any, they need to take to keep a child safe and promote their welfare.

[23] The ABE is a structured interview led by the Police, but also involving social workers to gather evidence for use in the investigation and criminal proceedings. In addition, any information gained during interview may also be used to inform enquiries regarding significant harm and any subsequent actions to safeguard and promote the child's welfare and in some cases, the welfare of other children.

abuse and exploitation by a number of men. Further Police investigations were started, but Lauren was not facilitated to attend follow up interviews and father ultimately reported that she did not want to pursue any further Police action; there does not appear to have been any work done to consider the reasons for Lauren's reluctance and what support could be provided. There also does not seem to have been any work to get father to support her. There were concerns about father's ability to keep Lauren safe and father was asked to allow Lauren to come into care on a voluntary basis[24]. He refused. The Police considered proceeding without a victim complaint, but because of evidential gaps this was not possible and no further Police action was taken.

3.20 The Child Protection inquiries agreed at the most recent strategy meeting were completed towards the end of December 2016 and acknowledged that Lauren was at risk of significant harm (but not having experienced significant harm); it was proposed that an initial child protection conference was not necessary and that a risk management plan was in place. There is little evidence regarding this plan.

2017: Lauren aged 15

3.21 At the beginning of January 2017, the school sought an update of progress from GCSC. SW2 replied that the Family Support Worker had seen Lauren and the family over the Christmas holidays and all seemed well. School were unhappy with the lack of progress and contacted GSCB. They were advised to share their concerns with senior managers at GCSC and this led to the Assistant Director for safeguarding providing managerial oversight; she asked that a strategy meeting be convened, a risk assessment completed and the required electronic recording brought up to date. These actions were shared with the school by the Head of Service (HOS) for safeguarding at GCSC who also asked for some information about Lauren's cognitive abilities. This information was provided, along with Lauren's EHCP. The HOS sought legal advice and there was a plan to hold a Legal Planning Meeting (LPM[25]); this did not happen.

3.22 At the beginning of January Lauren attended the sexual health clinic (SARC). She was worried about her health and there were some complex health issues identified which were exacerbated by the sexual abuse she was experiencing. At this appointment Lauren provided a worrying picture of extensive sexual exploitation

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[24] Section 20 of the Children Act 1989 sets out how a Local Authority can provide care/accommodation for a child within their area if that child is in need of it. Anyone with parental responsibility can voluntarily allow the Local Authority to place their child with an alternative carer under section 20 of the Children Act 1989.

[25] When social workers decide that the parent's care of their child is not improving enough to protect the child from significant harm, they will call a **legal planning meeting**. This meeting is for social workers and the local authority's lawyers to decide whether it is in the child's best interests for the parent(s) to be given a further period of support to improve their parenting, or to find someone else in the child's wider family to care for the child, or for the child to be removed from their parent's care straight away.

and sexual abuse by adult men causing her significant physical and emotional harm. This was shared with SW2 and other professionals. Lauren also shared similar information with the FSW2, youth worker and SW2.

3.23 On 18th January the Police officer from the CSE team sent an email to the Youth Support Team (YST) to say that although there were many professionals involved with Lauren, little progress had been made. The Police officer asked that the CSE outreach worker from the youth support team start work with Lauren and the Youth Support Worker who had seen Lauren for 6 individual sessions over the previous 10 weeks was replaced. The rationale for this change is not clear and occurred at a time when it was also planned that SW2 would be replaced by SW3. There were at least 5 professionals providing Lauren with direct individual support, and many others seeing her regularly in the context of her educational and health needs. There was no discussion about the impact of so many different professionals working with Lauren, the requirement for her to build new and changing relationships and the impact of this given her cognitive and emotional difficulties. It also remains unclear the purpose of the different interventions, many of which seem to duplicate the work of others.

3.24 A strategy meeting was held on the 19th January. SW2 did not attend and SW2's manager chaired via conference call. Lauren's learning needs were discussed in detail, but it remains unclear how this influenced the plan of action. It was agreed father would be asked to allow Lauren to come into care on a voluntary basis; which he refused. It was agreed that the child protection inquiries should continue, though they had been completed in December. It is unclear why this confusion existed.

3.25 After the strategy meeting school contacted the GCSC Assistant Director for Safeguarding to express concerns that the risks to Lauren had not been fully considered. The assistant team manager for SW2 replied, suggesting the focus required was on getting Lauren back to school. There was further discussion over the next few days about a referral to hospital education and this was made by Community Paediatrician 2 at the beginning of February 2017.

3.26 Lauren continued to attend a number of health appointments supported by her CSE youth worker; father did not attend. There remained concerns about her sexual and physical health, some unexplained physical anomalies and her walking/gait. These were all being appropriately investigated and addressed by health professionals.

3.27 On the 27th January a new social worker (SW3) from the specialist CSE team was allocated. She was tasked with completing a new assessment and convening a child in need meeting. GCSC had decided to wait for the completion of the single assessment before considering the need for an initial child protection case conference; causing further delay.

3.28 On the 21st February there was a CiN meeting. There was good multi-agency attendance and mother, father and Lauren also attended. It was reported that Lauren and her father did not want her to come into voluntary care, but father assured professionals that Lauren would be supervised as often as possible. There were concerns that some of the men harassing Lauren sexually lived in the flats around them. It was agreed that work would be undertaken with Lauren to say "No". Further evidence of the emphasis being on Lauren to be responsible for the harm she was experiencing. It was suggested that teaching her to say "no" was the only way of keeping her safe in the long term. There was no discussion of what action needed to be taken regarding Lauren's fear of the men in the flats where she lived.

3.29 A few days after the CiN meeting, there was a discussion by GCSC with their legal team. It appears a full history was not provided and the conclusion was that Lauren was at risk of harm from adults outside the home and therefore Police action was necessary but no care proceedings[26] would be possible. It was agreed that an Initial Child Protection Conference should be convened, but this did not happen.

3.30 Over the subsequent weeks professionals had concerns that Lauren looked unkempt, and had untreated head lice. She was observed to be hungry when she went out with the CSE outreach worker and she attended A&E after a fall and reported not to have eaten or drunk anything for 48 hours. She made further disclosures of sexual assault, rape and sexual harassment by many adult males. Lauren attended an ABE interview and disclosed a number of sexual assaults; these were investigated by the Police but could not be pursued due to evidential issues.

3.31 The GP made another referral to CAMHS because of Lauren's ongoing health problems which were thought to be likely caused by emotional difficulties. This was referral was not accepted. The GP also made contact with Community Paediatrician 2 and SW3 to express concerns.

3.32 The GCSC single assessment was completed mid-March 2017. This focussed on Lauren's health needs, issues of her understanding of consent and her cognitive capacity, without any conclusion being formed. Father's parenting was seen in a positive light. The assessment recommended that an initial child protection case conference be convened.

3.33 The ICPC was held at the beginning of April 2017. Lauren was made subject to a Child Protection plan for sexual abuse. She was supported to attend the conference by an independent advocate. Father met with the chair of the conference, but left before the conference started. There is no information available about his views. The concerns discussed were that Lauren was unsafe in her community because she was

[26] Care proceedings is the name for the court process when Children's Services go to court because they are concerned that a child is not safe. In care proceedings, Children's Services can ask the court to make an order to protect the child,

well known to perpetrators. There was no action agreed to address this. There were also concerns about her not being in school, and that father was not able to keep Lauren safe and protected from sexual predators. The plan focussed on asking father to attend all meetings, to understand the need to supervise Lauren and a family group conference to be convened; the purpose of this remains unclear.

3.34 At the end of April 2017 Lauren's EHCP was reviewed. This outlined the current level of support she was provided with in school, her poor attendance, her complex health needs and emotional fragility alongside her sexual abuse and exploitation. The plan was for her to attend college in September 2017.

3.35 In mid-May Lauren reported to FSW2 a sexual assault by an adult male she knew who she had been encouraged to meet to smoke marijuana. She was physically and sexually harmed. This was not reported to the Police and no action was taken. There should have been a strategy meeting, discussion about any criminal action and also to consider any health needs.

3.36 At the beginning of June 2017, Lauren was assessed by a Speech and Language (SALT) therapist which was initiated by the CSE youth worker. This assessment reiterated that Lauren had significant difficulties in understanding anything other than very simple language; she could not understand the word "safe", could only explain very simple events and had poor memory recall. This SALT assessment was shared with the FSW2 and SW2. The CSE outreach worker began adapting her materials for working with Lauren with advice from the SALT team, but would cease working with Lauren at this time due to unforeseen circumstances.

3.37 There were continued incidents of sexual assault and abuse of Lauren and she was supported to attend the SARC for health screening. There was a core group at the beginning of June 2017 where it was noted by SW3 that some progress had been made. The incident of sexual assault in May was discussed and there is no evidence that the lack of any action regarding this by GCSC was challenged.

3.38 In mid-June 2017 Lauren made a disclosure of rape to SW3. This was reported to the Police. An ABE interview was organised, but Lauren said she did not want to attend or go for a medical examination. Her father also said she did not want to engage and due to lack of evidence there was no action possible. Once again it is unclear how much work was completed to understand Lauren's reluctance and to get father to encourage the need for investigative action.

3.39 The first Review Child Protection Conference (RCPC) took place at the end of June. Lauren attended with an advocate; father did not attend. Father's lack of engagement was discussed. The need for a transition plan[27] for Lauren given that she

[27] If a child, young person or their carer is likely to have support needs when they turn 18, the local authority must assess them. There should be no gap in services. In England, when the transition between children's and adults'

was moving into adulthood was discussed but no plan agreed. Professionals agreed that Lauren remained at significant risk of harm and the CP plan remained in place. It was noted that father had not engaged fully with the plan and the chair of the conference concluded that "*if the high level of support continues to fail to protect Lauren from sexual harm by predators, and father is unwilling to agree to actions and/or is unable to keep Lauren safe the GCSC are to seek legal advice about possible care proceedings*. Given the circumstances and father's lack of engagement this was an appropriate plan.

3.40 Lauren was now aged 16. A new social worker was allocated, SW4. FSW2 remained as part of the team, along with a group of health professionals and the specialist CSE team continued to have oversight of Lauren's circumstances, but were not directly involved with the CP Plan.

3.41 Over the summer of 2017 Lauren had many appointments for her physical and sexual health. She continued to report being harassed sexually via her phone and there was a further reported incident of sexual assault that was not reported to the Police.

3.42 In September 2017 Lauren started to attend college and sought support from the pastoral support worker to delete social media applications and the telephone numbers of men who she did not know. In the first few months of college Lauren's attendance was 100% and she engaged well in activities provided.

3.43 In October 2017 Lauren told her GP that she had been raped. This was reported to the Police and she was provided with emotional and medical support. The Police started an investigation but there was conflicting information and Lauren then reported that she had consented to sexual activity with the two named suspects; as she was now 16 this meant no further Police action could be taken. Once again there was no action agreed to explore with Lauren about why she felt unable to follow through with an allegation of rape, professionals, including the Police, seemed too ready to accept that she had willingly engaged with sexual activity. Given her cognitive abilities, the long history of her being sexually exploited and sexually abused and her vulnerabilities this needed further exploration. There was a lack of reflection here of how hard it is for anyone to follow through with an allegation of rape, let alone someone in Lauren's circumstances.

3.44 At the end of October 2017 Lauren saw a Consultant Paediatrician 2 who told her about the outcome of the tests for her physical health and also discussed some findings which related to her cognitive abilities. The paediatrician made a referral to

services takes place, a local authority must continue to provide the individual with any children's services they were receiving throughout the assessment process. This will continue until adult care and support is in place to take over.

the learning disability team at CAMHS, which was reviewed, but was judged not to meet their criteria for a service and the Consultant Paediatrician was advised to make a referral to youth services.

3.45 At the end of November 2017, the second RCPC was held. Lauren remained subject to a child protection plan for sexual abuse given recent sexual assaults and exploitation. Father and Lauren did not attend the conference, and the chair again questioned father's commitment to the child protection plan; she asked that a Legal Panning Meeting (LPM) be held before the Christmas holiday. The plan going forward was SW4 would provide father with a list of expectations regarding ensuring Lauren was safe and to check her mobile phone. Father was also encouraged to take breaks from caring for Lauren; it is unclear what this meant but there is a sense of professional sympathy for a father parenting alone. There was to be a further referral to Children and Young People with Disabilities team (DCYPS). There was no mention of a referral to adult services and addressing the transition arrangements for Lauren.

3.46 Two weeks later a Strategy meeting was held which confirmed the need for a Legal Planning Meeting. Action was not taken until after the Christmas holidays and was only prompted by audit activity.

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3.47 In early January, Lauren's circumstances were reviewed because of an audit of cases undertaken in December 2017 as part of the Ofsted[28] monitoring visit to GCSC in January. The manager and Head of Service (HOS) responsible for overseeing Lauren's plan were alerted to delay and drift in this despite evidence of significant sexual and emotional harm. Senior managers and the Chair of the LSCB were alerted to the concerns. The head of service raised concerns about Lauren's cognitive capacity and ability to give consent to sexual activity. This was the first time this had been considered as an issue and the educational psychology assessment which took place in 2016 was used to guide thinking about Lauren. The HOS also raised questions about Lauren's complex health needs and the impact of sexual assault and abuse; another important issue, which was known about but not addressed. This head of service sought advice from the GCSC legal team and was told that the criteria for emergency action (an Emergency Protection Order EPO) had not been met and that a formal LPM was required. The manager was advised of the need for an expert cognitive functioning assessment of Lauren; this was commissioned.

3.48 In January the CSE team senior practitioner and a CSE Police officer visited Lauren and her father. They discussed recent concerns about the exchange of sexually explicit images. Lauren confirmed that images had been shared and a person was

[28] Ofsted is the Office for Standards in Education, Children's Services and Skills. They inspect services for children and young people.

arrested and questioned. There was insufficient evidence of criminal activity and therefore no criminal action could be taken. At this meeting Lauren reported being coerced and cajoled to meet many adult males, and that her father was not trying to stop this. The senior practitioner from the CSE expressed significant concern about the risks to Lauren and the lack of ability of father to keep Lauren safe from harm. This was discussed with SW4.

3.49 The next day SW4 and Team Manager 1 visited; they asked father again if he would give consent for Lauren to come into foster care voluntarily and father and Lauren said they did not want this to happen. Father was informed of the forthcoming legal meeting and was advised to consult a solicitor.

3.50 The Director for Safeguarding reported progress back to senior managers and the independent chair of the GSCB. She said that legal advice had been sought and although there were insufficient grounds for an EPO, the GCSC would compile evidence to seek a care order in the next week. This did not happen; it seems because in the short-term father's engagement (undefined) with professionals had improved. Team Manager 1 was spoken to about the lack of effective planning and consideration of Lauren's needs in the context of a child centred approach. He agreed that there had been some drift and would take action to address this. He would remain the team manager responsible overseeing Lauren's circumstances for the next 15 months.

3.51 In the second week of January a new social worker was allocated to work with Lauren and her father (social worker 5). On the 17th January Team Manager 1 sought further legal advice and was informed again that the grounds for an EPO had not been met and he was advised to hold a formal LPM and to make an onward referral to adult services; this was important in the context of thinking about transition arrangements, but did not happen. It is not clear why as this had been discussed some six months earlier at the Child Protection Case Conference.

3.52 The LPM took place on the 23rd January 2018 and was attended by both children's services and adult services lawyers. It was agreed that Lauren was at risk of significant harm (the records provided to the review focus on the future, rather than that Lauren had already experienced harm); a pre-proceedings meeting[29] was planned for 14th February which father and mother would be invited to. A psychological assessment was commissioned with a primary focus on whether Lauren would be able to understand and engage with any care proceedings that were undertaken. There was also a specific question about what work or strategies would help to keep Lauren safe from predatory males. It was also agreed that a

[29] Children's Services send a letter before proceedings to parents before a pre-proceedings meeting. This meeting is an opportunity for parents to discuss with Children's Services what they want parents to do to care safely for their child and to avoid a child being removed from their care. Parents will normally be given a further 6 weeks after the meeting to make necessary changes to keep their child safe.

mental capacity assessment would be undertaken and a referral to adult services. This referral did not happen.

3.53 On the 25th January SW5 & SW6 completed a mental capacity assessment[30] which found that Lauren did not have the capacity to consent to sexual activities, did not understand that she was at risk of sexual health risks, pain caused by the sexual activity exacerbating her complex health issues or any physical or emotional danger. This was important information which needed to be discussed in a multi-agency context with all agencies that were supporting Lauren and trying to keep her safe; this did not happen. It was agreed that SW5 would organise a best interest meeting[31] and an advocate would be appointed for Lauren. Lauren now had a mentor supporting her organised through college and a CSE youth worker (3) had been asked to provide Lauren with support.

3.54 The LPM took place on the 14th February. Only father attended; mother was invited but did not attend. The current concerns about Lauren being sexually abused and exploited were discussed. Father was asked to ensure Lauren was supervised, to monitor her phone use, to attend meetings and to agree to a capacity and cognitive assessment. It was agreed that the cognitive assessment of Lauren would be commissioned and a further LPM would be held in 5 weeks.

3.55 A best interests meeting was held on 27th February. The focus was on Lauren's lack of mental capacity to consent to sexual activity. There was discussion about what further Police action could be taken against a number of individuals as a consequence of this. Subsequently the Police were able to serve a warning notice to one individual to prevent further exploitation. It is not clear what other professionals were expected to do as a result of the mental capacity assessment. There is less clarity about what other agencies needed to do as a consequence of Lauren's lack of capacity in this area. From this point on the language used in records continued to suggest that Lauren was "*putting herself at risk of harm*" and was somehow making her own decision regarding the risk of sexual and physical harm; this was never an appropriate response, but after the mental capacity assessment was evidentially not true.

3.56 On the 28th February a joint risk assessment was completed by SW5 and CSE youth worker 3. This assessment brought together much of the history of concerns regarding sexual harm and exploitation, alongside Lauren's poor physical health. Lauren's views were recorded and although she said she understood professional concerns, she felt that she could not be stopped doing what she was doing; this was

[30] Under the Mental Capacity Act (MCA) 2005, professionals need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness of disability.
[31] A Best Interest meeting should be held where an adult (16+) lacks mental capacity to make a **decision** for themselves and needs others to make those decisions on their behalf.

not contextualised alongside her lack of mental capacity. Father's views are not included, despite there being a space for them to be; it is not clear whether his views were sought. The plan was for Lauren to have a simple phone, for father to report her missing and all professionals to carefully consider how to communicate with Lauren. This was an important plan going forward, but there was little analysis of what caused the significant level of abuse and exploitation of Lauren by others, what role father had played in the past and present and there was too much focus on Lauren as an agent of change, as opposed to those who were abusing her and the role her parents needed to play.

3.57 At the beginning of March 2018 there were further concerns about Lauren being cajoled into exchanging sexually explicit photos and this was investigated by the police. Lauren did not want to hand over her phone for evidential purposes and so no further action was possible. It is unclear how much any one talked to her about this. Professionals were also concerned that Lauren now had 2 phones which is not in line with the expectations of father outlined in the risk assessment recently completed. There is no evidence that father's role in this was challenged or addressed.

3.58 Consultant Paediatrician 2 wrote to CAMHS challenging their decision not to accept the referral regarding Lauren. CAMHS agreed to offer an appointment; she was not brought to an appointment in early March and a second appointment two weeks later was also not attended. Grandmother and father had telephoned to report Lauren's ill health as a reason. As a result, CAMHS asked their complex cases team to consider her circumstances and this happened in April 2018.

3.59 On the 14th March the review LPM was held and SW5 reported that father was engaging with the CP plan and progress was being made. It is unclear why this feedback was provided. Lauren remained largely unsupervised, and father was not monitoring her phone and suggested he did not understand the need to do so.

3.60 At the end of March 2018, the cognitive and capacity assessment was received by GCSC legal team. The assessments conclusion was that Lauren did not lack the capacity to understand pre-proceedings or to participate in court proceedings if that was necessary. Lauren was found to have a learning disability and in line with the two previous assessments of her cognitive ability, she was found to have poor language abilities, did not understand many common words, poor memory and she was not able to read material or understand documents. Her cognitive abilities were noted to be at the developmental level of a 7-year-old. In terms of the specific question about strategies for keeping Lauren safe from harm, the advice was "*when Lauren is intimidated and cajoled into non-consensual sexual activity' she needs to contact mentors and her family to support her (rather like alcoholics have supporters to contact when they need a drink)".* This advice suggested that Lauren understood

what was happening to her and did not hold the grooming behaviour of predatory adult men responsible for the harm Lauren had already experienced. The report also said that Lauren would be kept safe by the love of her family. This despite there being evidence in the report of a long history of neglect and Lauren telling the psychologist that there was no one who loved her.

3.61 On the 5th April 2018 the third RCPC was held with a new CP chair. Lauren and her father attended. Lauren remained subject to a CP plan for sexual abuse, but professionals agreed that progress had been made, the current protection plan was working and father was now more engaged. This was in stark contrast to the previous conference, held 5 months earlier, which had recommended legal action. The LPM had taken place just 6 weeks before this conference and the confidence of professionals appears to have been based on the period since then. During that time there had been ongoing concerns about Lauren being sexually abused and exploited, lack of attendance at appointments for Lauren and discrepancies regarding phones.

3.62 On 12th April Jem reported concerns about Lauren receiving explicit images; the Police investigated, but could not identify any suspects. They deleted the account from Lauren's phone.

3.63 On the 24th April Lauren came into college with evidence that she had self-harmed. Her injuries were treated, she was provided with support and SW5 informed. Lauren was encouraged by college to see her GP and she went the same day. Lauren told the GP that she was very low in mood and feeling that some professionals were not listening to her. The GP said he would speak to SW5 about these concerns and ask her to take them seriously; he also proposed that Lauren download a self-harm support application to her phone. The GP contacted CAMHS for an urgent appointment and also contacted SW5. CSE youth worker 3 discussed these worries with Lauren who said that she felt that professionals were stopping her from doing what she wanted to do. Lauren shared over time with these professionals that she craved love and attention; to be liked and much of the online activity fulfilled that need for her.

3.64 At the beginning of May 2018 SW5 was due to meet with Lauren, but she was not at home and SW5 reported her missing to the Police. Lauren returned home without Police action being needed. Lauren later told college staff that she had met with an adult male and had been cajoled into sexual activity. The college made a referral to Gloucestershire Rape and Sexual Abuse Centre (GRASAC) for support from an independent sexual violence advisor (ISVA). This was responded to 8 weeks later; the decision was that they did not have the capacity to support Lauren and also, she had not engaged with a previous offer of help.

3.65 On the 25th May the 13th core group took place. SW5 felt that progress continued to be made; she said there were now less concern about sexual exploitation and abuse

and father was working with the plan. Two days later SW5 reported concerns to the police about sexually exploitative messages being sent to Lauren. The police investigated, but it was not possible to identify the suspect; father was asked to remove Lauren's smartphone - an action from some months earlier which was not complied with.

3.66 On the 13th June 2018 the CAMHS practitioner from the complex case team visited Lauren at college and an assessment of her mental health needs started.

3.67 On 26th June Lauren saw Consultant Paediatrician 2 with CSE youth worker 3 who had supported her to write some questions beforehand regarding her different complex health needs. Consultant Paediatrician 2 answered all of Lauren's questions in easy to understand language and CSE youth worker 3 had brought visual cards of a thumbs up or down so Lauren could indicate understanding. This was followed up by an easy to read letter with answers to all of Lauren's questions. This was good child focussed practice.

3.68 SW5 was away on extended leave in June/July and CSE youth worker 3 and college mentor and staff were Lauren's main sources of support. The CSE youth worker liaised with the Police about the progress of various investigations related to explicit images being shared; Lauren refused to provide the Police with her phone. The CSE youth worker helped Lauren delete social media applications and messages.

3.69 The CAMHS assessment was completed and it was agreed a referral to the adult community learning disability team would be made to support Lauren into adulthood and to have her needs addressed. The CAMHS practitioner continued to see Lauren, to attend meetings and contribute to professional thinking about Lauren's circumstances.

3.70 SW5 returned from her extended leave in the last week of July in time to attend the core group held on the 27th July. At this meeting the ongoing concerns about the number and explicit nature of the messages that Lauren received from unknown predatory males on line was discussed. It was agreed the CSE youth worker would continue to support these being deleted and managing the social media accounts. It was acknowledged father had not enforced the requirement for Lauren to have a simple phone and the CAMHS practitioner expressed the view that Lauren remained at considerable risk of sexual exploitation and that father was unable to protect her. SW5 reported that there was no evidence that Lauren had been recently sexually assaulted (referred to as going out to meet men) but this was incorrect as she had made a recent allegation of sexual assault which father had said did not take place.

3.71 At the end of August 2018 SW5 discussed the progress of the child protection plan with her manager in supervision. She reported good progress, that father had engaged with professionals (no outcomes discussed) and that the incidents of sexual

exploitation and abuse had reduced; it is unclear against which criteria she was judging this. The manager proposed ending the pre-proceedings process and sought permission from the head of service.

3.72 Legal advice was sought and it was agreed that the pre-proceedings process was not needed and father was informed. Lauren would remain subject to a CP plan and once again it was suggested that a referral to adult services needed to be made given that Lauren was now 17. This had been discussed some 9 months earlier.

3.73 On the 20th September SW5 met with Lauren for the last time before she left the team. Lauren talked about being coerced into sexual activity with 2 men and how unhappy she was about this. SW5 discussed this with her manager a week later. SW5 considered that Lauren was at significant risk of sexual exploitation, that father was unable to keep her safe and had not confiscated/changed her phone when necessary. It was agreed there was a need to share concerns with senior managers and to liaise with adult services to plan and co-ordinate Lauren's transition and support into adulthood. This was an action from January which had not been completed and remained as an incomplete action for the following few months. SW6 was allocated to work with Lauren briefly.

3.74 The 4th RCPC took place at the beginning of October 2018. This was chaired by the chair of the first two conferences; providing much needed continuity and knowledge of Lauren's circumstances. The CP plan was reviewed and most of the actions had not been completed. The college said they had become increasingly more concerned about Lauren and there was evidence of ongoing sexual exploitation. It was reported that adult services would not engage with the CP plan, but as evidenced by SW5's recent supervision, it seems likely they had not been approached. The conclusion from the chair of the conference was that father had not been able to keep Lauren safe. The chair asked that an urgent meeting be convened between the head of safeguarding, legal services and the vulnerable adults' team to decide on next steps to safeguard Lauren. This was an appropriate proposal, but did not happen.

3.75 A strategy meeting was convened 9 days after the RCPCC and focused on the risks posed to Lauren of 2 adult males who were known to be perpetrators of the sexual exploitation of other young people locally. A further complex strategy meeting was held and the Police were able to issue disruption notices to 3 men regarding Lauren's lack of capacity to consent to sexual activity.

3.76 A new social worker was allocated (SW7) with the same team manager overseeing the work. SW7 was immediately concerned about the extent of sexual abuse and exploitation that Lauren had experienced and her father's lack of cooperation and inability to act protectively. She noted that father had refused to limit Lauren's access to a smart phone and had purchased an Apple iWatch for her so she could continue to receive and send messages. SW7 organised a core group meeting for the

13th November 2018. At this meeting professionals shared significant concerns about Lauren's use of social media and being sexually exploited by many predatory males. It was agreed that legal advice would be sought. An LPM was held on 14th November and the legal advice was that no order under the Children Act 1989 could be sought because Lauren was nearly 18 and advice needed to be sought from the adult services legal team. SW7 started to ensure that Lauren was discussed at weekly complex strategy meetings where known perpetrators of sexual exploitation were mapped.

3.77 On the 15th November Lauren said she had been raped; it is not clear who she told, but this was investigated by the Police and led to no further action due to a lack of evidence and the suspect providing an alibi. CSE youth worker 3 organised for Lauren to seek sexual health advice and whilst there Lauren reported further incidents of coercion to engage with sexual activity with a number of adult males. The sexual health centre and CSE youth worker talked to Lauren about the abusive nature of this.

3.78 On the 29th November Lauren came into college with superficial wounds to her legs and she said she had stabbed herself with scissors. She went to see the GP and said that a boy had told her to kill herself. The GP noted that Lauren looked unkempt and tearful and suggested she come back for a follow up discussion in 2 weeks' time.

3.79 On the 5th December a further LPM took place attended by head of service and the head of service for disabled children. The advice given was the same as at the previous meeting, and the need for the adults' social care legal team to be involved was reiterated.

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3.80 On the 9th January the Head of Service for Safeguarding sent an email to the children's legal team challenging their decision not to start care proceedings and querying the involvement of the adult services legal team. The reply reiterated the previous advice and confirmed that a referral had been made to the principle lawyer in the adult legal team.

3.81 The 5th RCPC was held on 11th January and chaired by the same chair. Lauren attended, and an advocate read out her views. Father did not attend; he had made it clear that he considered the meetings a waste of time and would not work with any professional. It was reported that father had opposed professional advice about Lauren's phone and use of social media. Professionals agreed that little progress had been made in 2 years and that a referral to the vulnerable adult's team was required. There was a follow up meeting two weeks later which reiterated the same concerns. A representative from adult services was present and the only decision recorded in the information available to this review was that action would be taken

through the court of protection[32]. The CAMHS practitioner made a referral to the community learning disability team; he had previously been advised that Lauren would not meet the criteria for support.

3.81 On 18th January adult's legal services allocated a solicitor who made contact with SW7. There was some email correspondence, but no immediate action and 6 days later a new solicitor was allocated. There was further discussion, but a legal meeting would not be held for another 6 weeks. There was no explanation for this ongoing delay and no challenge of it.

3.82 Over the next few weeks Lauren told professionals that father had brought her a new smart phone and her use of social media increased; she was contacted by many adult men and asked to exchange explicit photographs. She also told professionals about being persuaded by a number of men to take part in sexual activity. She reported that her father and sister asked about these encounters, and accepted they were taking place. Lauren reported that her father knew the perpetrators by sight, was aware of their plans and did nothing to stop the abuse; in fact, Lauren said he would be prepared to take her to meet men. Lauren also reported that father had hidden a smart phone, in case professionals removed her phone. This information was shared with the Police by SW7, but led to no further action.SW7 shared the names of sexually exploitative men with the CSE Police team, and asked that disruption notices were served. Some were, but SW7 was told on 13th February that "*they could not serve disruption notices on everyone she has sex with*". SW7 was also told that Lauren could not be interviewed successfully because of her learning disability.

3.83 On the 25th February Lauren was supported by the CAMHS practitioner and pastoral support from college to attend an assessment with the Adult Community Learning Disability team (CLDT). Afterwards she told CSE youth worker 3 that she did not want adult social care support and nor did her father; Lauren said father had told her to avoid any contact with them. The CLDT concluded that Lauren had no underlying mental health issues and therefore they could not offer her services. They did comment that Lauren seemed very vulnerable and at high risk of sexual abuse and exploitation. They felt that she would likely need trauma services in the future when her circumstances were more settled and she was safe from harm.

3.84 CSE youth worker 3 went to see Lauren on 1st March 2019 to take her to the planned core group meeting. Lauren said that she had recorded the names of men who had persuaded her to engage in sexual activity recently in her notebook and father had ripped the pages out. Lauren was tearful, said that she wanted someone to look

[32] The Court of Protection in English law is a superior court of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who lack mental capacity to make decisions for themselves.

after her properly and that her father did not care about her or what she did. She asked if she could come into foster care voluntarily. This was discussed with the HOS by SW7. SW7 sought foster placements but could not get through to Lauren. SW7 spoke to Lauren late in the afternoon and Lauren said she had gone out with Jem who had left her alone with a man who had sexually assaulted her. Lauren said that she would wait until she was 18 to leave. Father and Lauren's sister Jem could be heard being very aggressive and said Lauren was safe.

3.85 SW7 contacted the Police to ask if they could use Police protection powers to remove Lauren given, she had been sexually assaulted on four occasions that week. They said the risks had not changed and so no action could be taken. The name of the man who had sexually assaulted/raped Lauren was shared with the Police, but no disruption notice was served. It has later become known that this man had his children removed by GCSC.

3.86 On the 8th March Lauren reported to youth worker 3 that her father had dropped her in town for the day. She was persuaded by a man to meet him and he sexually assaulted her. Lauren said that father knew that this was likely to happen but did nothing to address this. The incident and the name of the man was shared with the CSE Police team, but no disruption notice or any other action was taken.

3.87 On 14th March SW7 and her team manager visited Lauren. Lauren said that her father did not want them to come into the flat, but she could speak to them on the landing. When spoken to Lauren said that no one was keeping her safe. At this point father came out; he ignored SW7 and the team manager and told Lauren to get ready to go to the local social club with him. This was a place Lauren had talked about where she had been approached by predatory men and had been sexually abused and exploited. She had made father aware of this on many occasions. SW7 and the team manager left.

3.88 The next day CSE YW3 saw a post on social media from Lauren saying "*I am feeling broken. I am not worth it to be in this world. I should be dead*". CSE YW3 visited immediately. Lauren said that she was being harassed by a man from the midlands who was sending explicit photographs and asking her to do the same. He had proposed that they meet at a hotel, where he would give her alcohol and money in exchange for sexual activity. This information was shared with the Police and SW7. SW7 sought legal advice and an Emergency Protection Order was sought and granted; Lauren was taken into foster care. She has remained living away from home and protection sought for her through the court of protection.

4. Analysis and key themes

4.1 The purpose of any Serious Case Review is to explore the strengths and weaknesses of the local and national safeguarding system and to consider action required to address gaps and promote effective practice. The intention is to understand how well a child's needs for safety and care were met and what might have been influencing the professional response at the time. There are 6 key concerns arising from a review of Lauren's circumstances and these form the finding that follow:

Finding 1: The importance of an effective professional response to the sexual abuse and exploitation of children (those under 18)

Finding 2: The importance of recognising the specific needs of disabled children and young people and responding appropriately.

Finding 3: Recognising, assessing and responding to adolescent neglect

Finding 4: Understanding Relational and Developmental Trauma; the importance of professional recognition that this causes increased vulnerability to children and negative impact on children's lives

Finding 5: Dealing with professional disputes and differences of opinion in ways that put the child and young person at the centre.

Finding 6: The operation of routine support and safeguarding processes for Lauren

Finding 1: The importance of an effective professional response to the sexual abuse and exploitation of children (those under 18)

Child Sexual Exploitation (CSE) is a form of Child Sexual Abuse (CSA). It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child Sexual Exploitation does not always involve physical contact; it can also occur through the use of technology. It can involve children and young people of all ages and genders from all social and ethnic backgrounds.

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening

4.2 The first key finding ls about the professionals' response to sexual abuse and sexual exploitation. The sexual abuse, sexual exploitation and sexual violence involving children and young people are a significant and serious issue which is known to impact negatively on all aspects of a child or young person's development, with serious long-term physical, emotional, social, educational and mental health consequences. There were several issues related to the response of professionals to the sexual abuse and exploitation of Lauren in 7 key areas:

- Early action;
- Language;
- Understanding sexual exploitation as significant harm;
- The importance of a holistic and planned approach;
- Investigating crimes and disruption;
- Disclosures as help seeking behaviour;
- Case holding of CSE cases by the CSE specialist team.

The Importance of early and prompt action to address the exploitation of children and young people

4.3 It is essential that children and young people affected by sexual abuse and exploitation are effectively safeguarded and that action is taken early to prevent patterns of offending behaviour developing and becoming entrenched without action from outside agencies; this can leave children and young people feeling like their circumstances are spiralling out of control without any immediate solution. This is what happened to Lauren.

4.4 Lauren experienced sexual abuse, sexual violence and sexual exploitation by many different predatory men over at least a 3-year period. There were concerns in November 2015 about Lauren being targeted online by predatory males to sexually exploit her when she was 14. The school she attended were appropriately concerned and made a referral to GCSC. This was not initially responded to, but after school escalating this lack of action, a strategy meeting was held.

4.5 This strategy meeting decided that no action was necessary and that the existing family support work would continue; despite there being no evidence that any part of the family was engaging with it. There was a lack of specific action agreed to explore what was happening to Lauren, which adults were involved in her exploitation and what action was necessary to address this. Although this was the first incident of concern, there had been a long history of neglect and this was an important early opportunity to undertake an assessment and address the concerns about the adult male behaviour.

4.6 In February 2016 the school noticed that Lauren was exhibiting signs of emotional distress (expressed as aggressive behaviour) and when this was discussed with her,

she provided a picture of a chaotic home life with her father where there were clear problems with sexual boundaries and a lack of care, attention and supervision. Lauren also described visiting her mother's home at weekends where parties were held and Lauren said she drank alcohol excessively; Lauren's sister told school that an older man (29) was hanging around and she was concerned this man might be sexually assaulting Lauren. School continued to be notified of sexually explicit content on Lauren's social media accounts.

4.7 Once again, school made a referral. There was considerable delay in action being taken. There was a strategy meeting and an assessment by GCSC which led to Lauren being subject to child in need processes. There is no evidence that this focussed on the behaviours and activities of the many men who were targeting Lauren. Early action could have sought to prevent the growing number of adult men being in contact with Lauren and address the pattern of offending behaviour and Lauren's response to it. Lauren was clear that the experiences were scary and harmful, but that she also craved attention. This meant that men were able to take advantage of her. At this point it was also not known that her cognitive difficulties impacted on her ability to always predict the risk she might be in.

The language used about sexual abuse and exploitation

4.8 National Guidance[ii] makes it clear that the victims of sexual abuse and sexual exploitation should never be held responsible for the harm they have experienced. Many high profile SCRs[iii] [iv] have highlighted the tendency of professionals to use language which unintentionally implies that the child or young person are in some way responsible for what had happened to them, either through their own actions, such as "engaging in risky behaviour" or "dressing sexually inappropriately" or through their existing vulnerabilities such as learning disabilities, poor mental health, previous experience of neglect. This has led to children and young people feeling they are to blame for what has happened to them, and this often echoes the language of abusers. This may prevent a child or young person from disclosing their abuse, through fear of being blamed by professionals. When victim-blaming language is used amongst professionals, in meetings and in reports there is a risk of normalising and minimising the child's experience.

4.9 It is clear that all the professionals who had contact with Lauren were very concerned about her and the harm she was experiencing. There were lots of ways, however, in which language was used which implied that she was making a choice to link with predatory adults, or simply choosing to go and meet them This was to confuse the choice to meet, with the need for attention and the action of the various men who took advantage of the meeting to sexually assault Lauren. There were comments in records that "*she was dressed in an overly sexualised way*" as if this contributed to the harm she experienced. The issue of coercion and control was

never clearly enough articulated and Lauren was described as "*going off with men*", "*meeting men*", "*engaging in sexual activity*". There were implications that she lied and that this "*was very much Lauren*". This was completely inappropriate and is discussed in the findings that follow.

4.10 It is of concern that the psychological assessment commissioned as part of the possible care proceedings in January 2018 referred to Lauren's "promiscuous behaviour". This report was read by many of those involved, but this phraseology was not challenged.

4.11 In March 2018 it became clear through a Mental Capacity Assessment (MCA) that Lauren could not consent to sexual activity. Despite this professional records still suggest that she was choosing to go and meet with men for sexual activity and using the language of "engagement with sexual activity". This was not possible for her. She was choosing to get attention not abuse.

4.12 From the end of 2018 until when Lauren came into care there were escalating concerns about the level of abuse, rape and assault she was experiencing. At this point it was very clear that she could not consent and was being exploited. The Police members of the CSE team told SW7 that they could not issue disruption notices to "all the men she (Lauren) had sex with" and said that "*She is not doing herself any favours with her pictures on Facebook."* These were inappropriate comments that needed robustly challenging.

4.13 It is imperative that appropriate terminology is used when discussing children and young people who have been exploited, or are at risk of exploitation. Language should reflect the presence of coercion and the lack of control young people have in abusive or exploitative situations, and must recognise the severity of the impact exploitation has on the child or young person.

Understanding sexual exploitation as significant harm

4.14 It is the responsibility of children's services departments, in partnership with other agencies to establish whether a child or young person in their area is at risk of, or suffering significant harm. "Harm" is the "ill treatment or the impairment of the health or development of the child". Significance is determined by "comparing a child's health and development with what might be reasonably expected of a similar child"[v]. Although there are no set criteria for determining whether or not harm is "significant" a decision is made based on assessment and professional judgement using the available evidence. If a child is found either to have suffered significant harm or being at risk of significant harm an initial child protection conference should be convened in order that the risks to the child can be considered in a multi-agency context. The criteria here are not the behaviour or attitude of the adults/parents in a child's life but the harm to them and how attributable it is to the care they have

experienced/will experience. A confusion that was evident regarding decision making for Lauren.

4.15 There was considerable evidence from the start of the review period and across it that Lauren had experienced significant harm on a number of occasions. Decision making regarding this was slow and characterised by drift and delay. There was a strong focus on likelihood of significant harm, that the harm was somehow in the future, and a lack of acknowledgement that the harm had happened and was continuing to happen. A firmer response was required. Lauren was raped in March 2016 by a predatory male known to Lauren's mother. He made contact with Lauren seemingly at a party held by mother, in which Lauren was very drunk. There had been concerns about poor parental supervision and a lack of sexual boundaries at home. A strategy meeting was held, child protection inquiries undertaken, but the conclusion was that a child in need plan would be implemented; the caveat was that an ICPC would not be held if father made the required changes to his parenting. Lauren had experienced significant harm. The evidence was the actions of the adults; sexual assault by men, poor care and supervision by both parents. The impact was clear; she was self-harming and was struggling to emotionally regulate herself characterised by angry outburst and aggression at school and home. The decision should have been for an ICPC to be held.

4.16 There was considerable drift with the CiN plan from GCSC which was challenged by other agencies. The significant harm was not addressed. This was caused by the pressures on GCSC at this time, problems with assessment processes but also some attitudes to Lauren. She continued to be seen as making poor choices, and engaging in meeting men. Her father was characterised as struggling with her behaviour, rather than being a parent who provided no emotional care (he told professionals he was a reluctant parent) or putting boundaries in place for an adolescent (he spent much of the time away from home with his girlfriend). The perceived struggle of father to manage Lauren's difficult behaviour as opposed to recognising the corrosive impact of trauma led to a referral to the diversion from care team with a focus on helping father deal with Lauren's behaviour, rather than a focus on the harm she was experiencing.

4.17 In April 2017 Lauren became subject to a CP plan when the significant harm she was experiencing was recognised by GCSC; all other agencies had been pushing for child protection action from March 2016. There was an escalation caused by Lauren's circumstances being reviewed in an audit completed by GCSC. Legal advice was sought and GCSC were advised to hold a legal planning meeting. This was an opportunity for GCSC to consider whether the threshold for legal proceedings had been met and what action was needed to be taken by both parents. The threshold criteria for care proceedings is that a child is experiencing significant harm and the

harm is connected to the quality of parental care being provided. This clearly was the case here.

4.18 Few expectations were placed on father in the pre-proceedings plan, and none were placed on mother, despite Lauren continuing to visit and there being previous evidence of poor boundaries being provided by mother enabling predatory males taking advantage of Lauren. The pre-proceedings process lasted for a six-month period within which Lauren continued to be harmed and father and mother do not appear to have been required to take any action or evidence any change to ensure she was safe. This was a further opportunity to recognise the significant harm that Lauren was experiencing daily and take authoritative action to address it. Father was asked on a number of occasions to allow Lauren to come into local authority care under a voluntary agreement. He refused; this is not surprising given that it is clear that he did not recognise or acknowledge his role in keeping Lauren safe. This left father as the decision maker for Lauren's safety. Something that was inappropriate.

4.19 Ultimately evidence emerged that father asked Lauren about her experiences of sex, facilitated access to a smart phone, treated the perpetrators who abused her as acquaintances and drove her to meet adult predatory males. It is of concern that this was not enough evidence to take action for an emergency order and no Police action has been taken to address the behaviour of father and should be a matter of review.

4.20 GSCB have published a number of SCRs that indicate that there is a lack of recognition within GCSC about significant harm and the actions needed to address it. Lauren's circumstances highlight that this remains an issue of concern.

Addressing sexual abuse and exploitation: the importance of a holistic plan and approach

4.21 The serious harm that sexual abuse and sexual exploitation causes to children and young people's emotional and physical health is clear and requires swift and multi-faceted interventions based on good quality assessment. However, addressing sexual abuse and sexual exploitation is complex and just like any safeguarding concern requires a coordinated multi-agency response which addresses the holistic needs of a child or young person and their family. Addressing sexual exploitation[vi] requires a multi-facetted response including:

- ensuring that crimes are effectively investigated and those responsible brought to justice, and that where possible perpetrators coercive and controlling behaviour is disrupted through a disruption plan;
- Addressing the individual circumstances of a child or young person, across their educational needs, emotional needs, physical health needs and addressing the impact of trauma;
- Working with a young person on issues of safety. This requires safety planning and making sense of coercion, control and grooming and helping children and

young people to make sense of this for themselves. Research suggests that although educating children and young people about healthy relationships and the process of grooming is helpful, this approach does not increase safety because it is not the behaviour of the child or young person that causes the abuse. There is a danger that a focus on education about healthy relationships suggests that the child or young person can keep themselves safe by their own efforts and may imply the abuse is the child or young person's responsibility.

- Addressing any co-existing vulnerabilities such as other kinds of abuse and neglect and working with parents to enhance safety of the child young person and to provide emotional support.

4.22 Lauren was recognised as a child who was being sexually exploited from November 2015. The first support offered was through the family support service, Families First. This response did not directly address threat to Lauren posed by predatory men and instead focussed on her behaviour and support to father to manage this. The issues of sexual exploitation were focussed on individual support to Lauren and Jem to recognise abuse. This was not enough.

4.23 Concerns then escalated with Lauren making disclosures of rape and sexual assault; this harm to her led to a single assessment being completed by GCSC. This assessment did not address the concerns about sexual exploitation or propose any action. Lauren became subject to a child in need plan. This was never really formulated, but it did not address sexual exploitation or that Lauren had been raped aged 14. This pattern was to continue. There were further reassessments and CiN meetings, but no CiN plan and no focus on sexual exploitation, Lauren's wellbeing, her emotional needs or her health needs as a result of the sexual abuse, addressing perpetrator behaviour or how father and mother could keep her safe.

4.24 There were many agencies involved. School were focussed on education, addressing Lauren's learning needs, but also her emotional health and wellbeing. There were two FSWs involved, one from Families First and the other from the diversion from care team; both were trying to address family relationships and father was offered attendance at a parenting programme which he rejected. The FSW was also helping Lauren build self-care skills which were very underdeveloped. The GP and Paediatrician addressed Lauren's physical health needs and tried to get her some support for her self harm and low feelings. The school nurse provided support. The Police were investigating the crimes Lauren reported. The ISVA was supporting Lauren regarding criminal processes and the youth worker was doing work with Lauren about safe relationships and keeping safe. This was a lot of support which was not coordinated into one plan focussed on the core issue of sexual abuse/exploitation and the impact on all aspects of Lauren's life.

4.25 Each agency carried out its own plan of action, without this being connected to the child in need process. This led to some duplication of activity. There was a lack of overall objectives; there was no clarity about what the package of professional involvement was hoping to achieve for Lauren. The work of the Police happened in almost total isolation. This was despite Lauren sharing information about sexual crimes committed against her. She gave names, talked about locations and places she was frightened of. This information was shared across the professional network, but there was no mapping of this information until October 2018 and no discussion about the need for disruption activity as part of the CiN plan.

4.26 When Lauren said she was reluctant to attend Police interviews, there seems to have been little discussion about how this might be addressed. There was also no discussion about the impact of her learning needs on her ability to take part in police interviews/ABE processes. This is not to say that all professionals did not try and be part of a wider plan. They showed huge commitment to do so; an overarching plan bringing all of the services together did not exist.

4.27 From April 2017 for a period of 2 years Lauren was subject to a CP plan for sexual abuse. There were regular child protection case conferences and many core groups over this period of time. The package of services and involvement of agencies remained much the same as under the CiN process. The lack of coordination remained, and there does not appear to have been clear objectives to be achieved or an outline of what needed to be changed or how to address the sexual abuse and exploitation Lauren was experiencing.

4.28 At a number of stages of Lauren's journey through services the CSE assessment tool was used. It remains unclear how this influenced the professional response or how it was helpful in keeping her safe.

4.29 Child Sexual Abuse and Exploitation is complex; it is often difficult to create change and keep children and young people safe. What is required is a holistic multi-agency coordinated plan. This did not happen sufficiently for Lauren. It is also important that all professionals consider the balance across the work between the focus on the victim of sexual exploitation and the support they might need, action to ensure that parents do all they can to protect, nurture and support a child or young person and action to address the criminal behaviours of perpetrators and action to disrupt offending. Victims of sexual crimes and exploitation need to know that professionals will put equal energy into preventing CSE happening, protecting and supporting victims and pursuing and disrupting offenders. If the focus of support is on the child alone there is a danger that this will imply that it is the victim's fault, they were abused and they are alone in making it stop. The balance was not always right for Lauren.

The investigation of crimes.

4.30 Over a three-year period, Lauren made at least 23 allegations of sexual assault which were shared with the Police; 10 of these allegations were about rape. Only 1 resulted in a prosecution and this took over 2 years. There is evidence that the Police investigated these allegations, and experienced difficulties with evidence. Lauren was often described as being unwilling to attend Police or ABE interviews and her father also often said they did not want to pursue any inquiries. There was insufficient multi-agency discussion regarding what to do about this and little exploration of what this was about. This review does not know why Lauren felt unable to attend interviews; whether she was frightened or embarrassed or not supported by father. This should have been a focus of the child in need process, the many strategies meetings/discussions that took place and also the CP conferences that were convened. This would have helped the investigation process over time.

4.31 There is some evidence that the CSE Police team had fixed views about both the reliability of Lauren's testimony, blaming her for what happened to her and that she was an unreliable witness. This left her without a sense that she deserved justice.

4.32 Lauren also had a learning disability. The details of this were provided through an assessment in June 2016 where it was found she had problems with memory, very low-level basic literacy and numeracy skills, considerable difficulties with reasoning, problem solving and the ability to hold onto information. There were further assessments in June 2017 and March 2018. All came to the same conclusion that Lauren was operating at a cognitive level at a chronological age of 8yrs and could not learn from her negative experiences.

4.33 It is not therefore surprising that Lauren gave contradictory information. This was not helped by father and her sister also undermining her version of events on a number of occasions. The ABE guidance[vii] requires those conducting the interview to consider the child and young person's needs before an interview takes place, including family background, any special needs, the child's cognitive, memory and linguistic abilities; current emotional state and relationships with family members.

4.34 The chronologies and Independent Management Reports (IMR) provided by the Police and GCSC provide no information about who conducted the ABE interviews, and how much planning took place to make Lauren more comfortable (included in the ABE guidance) and to address both her learning needs and the impact of the traumatic events she experienced. Although these two agencies are primarily responsible for undertaking ABE interviews, other agencies who know a child well can check to see what preparations have been made and how they can help. There is no evidence that this was discussed in any of the many multi-agency meetings that took place.

Disruption activity

4.35 There was discussion of activity to disrupt the behaviour of possible predatory males by the Police, but this was inconsistent and there were concerns expressed by professionals in late 2018 that more could have been done regarding child abduction warning notices[viii] when it was found Lauren could not consent to sexual activity. When this was shared with the Police the view was expressed "*that they could not serve disruption notices on all the people she had sex with*"; this was completely inappropriate and unacceptable practice[33]. It has emerged that one of the adult men who exploited Lauren had his children removed from his care and that there were emerging issues regarding sexual boundaries. This is why addressing the sexually abusive and exploitative behaviour of men is important; there is rarely one victim.

4.36 There could overall have been more discussion across the multiagency network in partnership with the Police to consider what could be done. Research highlights the importance of a disruption plan to reassure victims that everyone is taking their disclosures of harm seriously.

Children and Young Peoples disclosures: help seeking behaviour

4.37 Following on from the criminal action taken to address Lauren's disclosures of sexual abuse, assault and exploitation it is important to consider how these disclosures were dealt with. Whenever children or young people make disclosures or tell professionals that something is happening for them, they are being harmed or are worried about something they are developing and maturing their help seeking behaviour. Like any other developmental skill, children need to learn how to seek help from others. Children and young people who have been abused and neglected have the development of their help seeking behaviour interrupted. They may live in households where they are threatened not to tell professionals anything or to seek help, and they may also experience blame from those looking after them signalling that the abuse or harm was their fault. They may also find that they tell professionals their concerns, and the help seeking either does not work, because nothing happens, or makes things worse because those who are harming them are alerted and there is further abuse as a consequence.

4.38 Lauren made many allegations that she had been harmed to professionals. This did not lead to action in most cases against those who had harmed her. The previous

[33] At that time the males in contact with Lauren were not all identified and in fact it was not possible to identify them all, as a result it was not possible to issue disruption notices to all of them. Lauren continued to use social media and post images of herself in which she could be perceived as an adult/over 18, this made the perusal of online offending extremely difficult as it was not possible to prove that males who then engaged with her, knew she was a child, she was therefore inadvertently exposing herself to risk. Many professionals spoke to Lauren about this in an effort to manage the risk and educate her about online safety.

section has highlighted the importance of a disruption plan and this could have provided reassurance that action was being taken. The criminal processes for the rape in March 2016 took 2 years. This bothered Lauren. More could have been done to reassure her that the Police were taking the issue seriously. It is not clear how the lack of criminal action in her other disclosures was discussed with her. There was some sense that this was her fault because she would not attend interviews, or share her phone with the Police. What was needed was a more sophisticated understanding of what was going on for a child who had been abused, neglected and harmed and who could not call on her parents for advice and support.

4.39 Professionals need to promote help seeking behaviour in children and young people and enable them to seek help; not leave the responsibility with the child. They need to recognise and address barriers and ensure an ACTION, CONSEQUENCES, REPAIR approach. That is professionals are clear what action is being taken by whom, with what outcome, and when. If there are no formal outcomes possible, the message should not be "*this agency cannot do anything because there is not enough evidence*" but a focus on what can be done; what action can be taken, however small. Children and young people need to know it was worth telling someone. Children and young people need to have what happened to them acknowledged as wrong and harmful, even if there is no formal outcome possible. Finally, children and young people need some form of repair; their parents, carers and important adults saying sorry about what has happened. In the early disclosures of abuse, this did not happen for Lauren. Her help seeking was not promoted.

The role of the CSE team

4.40 This review had as a specific term of reference a question about whether the specialist CSE multi-agency team should be case holders for children and young people who are being significantly sexually exploited and harmed by predatory males. The Independent Management Reports (IMR) provided by agencies draw no firm conclusions about this. The picture for Lauren is confusing. At times she was provided with a social worker from the district teams and at other times the CSE team were the key worker. This led to a number of changes of professionals working with her and did not seem to improve the response to her safety.

4.41 This review cannot draw a firm conclusion; it can highlight that this decision needs to be based on the assessed needs of the child or young person. Where there are high levels of co-existing vulnerabilities, as with Lauren, she needed a social worker who was addressing the underlying issues of neglect and potential emotional abuse. She also needed the CSE team to be addressing disruption of perpetrators behaviour, taking forward Police investigations, thinking about the link between the Police and the child in need/child protection plan. What is always needed is clarity of role and task to address the holistic needs of a child or young person. That was missing here.

A recent Gloucestershire SCR draws the conclusion that there should be a clear lead professional to ensure multi agency involvement is properly coordinated and that the child or young person has a single point of contact. This would have been helpful for Lauren and her family.

4.42 This review has highlighted weaknesses in the multi-agency response to the child sexual exploitation and sexual abuse in Gloucestershire despite considerable guidance and training being available and a specialist team in place.

Recommendation 1: The Gloucestershire Local Safeguarding Children Executive (GSCE) needs to ensure that action is taken to address:

1. Where early help plans are deemed an appropriate response to the early signs of sexual exploitation. That the sexual exploitation itself is addressed directly and not just focussed on addressing family difficulties or programmes designed to educate young people.
2. Ensure that there is a process in place whereby all children who are subject to a CiN plan or CP plan because of sexual exploitation have a disruption plan in place which would be incorporated into these wider plans.
3. In cases of sexual exploitation nationally there are well documented concerns about the engagement of vulnerable, traumatised and abused young people in action to address their abuse. The causes for this are well known and should not be automatically focussed on a failure in the young person. Professionals need to be supporting young people, addressing their fears and reluctance, alongside recognising their capacity. This should be a routine part of the early help/child in need/child protection planning and discussion process.
4. There were considerable concerns that the vast majority of professionals working with Lauren struggled to avoid victim blaming language which implied choice and control. Some professionals went further and actively implied "promiscuity". All seemed to lose sight that she was a child with a learning disability who was being exploited. This remains a national and local issue which the GSCB will need to consider how best this can be addressed, The Children's Society and other agencies have produced guidance about language. This is not a solution because this is about attitudinal change, but might be a helpful starting point[34].

Finding 2: The importance of recognising the specific needs of disabled children and young people and responding appropriately.

34 https://www.csepoliceandprevention.org.uk/sites/default/files/Guidance%20App%20Language%20Toolkit.pdf

A person has a disability if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. Equalities Act 2010

4.43 This finding focusses on whether agencies and professionals identified Lauren as a disabled child with extensive learning needs and the extent to which this influenced their response to her in a child centred way. The UN convention on the rights of persons with disabilities and the Equalities Act 2010 make clear the importance of disabled children having their identity as a disabled person recognised, their needs met, their capacities enhanced and reasonable adjustments made to ensure that they get the same benefits from services as any other child or young person.

4.44 Lauren had a learning disability from early childhood. These early cognitive difficulties may well have been exacerbated by the neglect she experienced as a young child. When Lauren started at school in 2013 in Gloucestershire, having been home educated in another county, there was a recognition that she had learning needs and she was provided with specialist educational needs support. In 2016 there were concerns about her coping mechanisms and appropriately the school instigated the Education, Health and Care Plan (EHCP) process. This included a psychological assessment, and from this a clear outline of Lauren's cognitive abilities and challenges emerged. She was found to be considerably behind her peers, had poor problem-solving skills, impaired memory and struggled to understand words and concepts. The school put in place a programme of support and a modified timetable based on this assessment.

4.45 GCSC undertook a single assessment of Lauren and her family in April 2016. This described that Lauren was functioning at "around age 6-7" without any analysis of what this might mean for the CiN plan or professional involvement with her. There was no CiN plan and so this was not addressed. There were a number of re-assessments within the CiN process which did not address Lauren' cognitive style and there was no plan.

4.46 In October 2016 the family support worker (diversion from care team) discussed her concerns about Lauren's cognitive capacities with the youth worker. As a result of this they agreed to modify their approach and there is evidence that information was provided to Lauren using appropriate communication and visual imagery. This was good practice.

4.47 These two workers were not included in the many strategy meetings held, and so their knowledge of Lauren's learning style built up through working closely with her, was not part of the discussions. There is evidence that Lauren's cognitive abilities were discussed, but it is unclear the extent to which this influenced the broader plans to keep her safe and ABE interviews. There is no evidence regarding what planning or reasonable adjustments were made.

4.48 It was also good practice that the youth worker commissioned a speech and language assessment in June 2017. This informed the work of this agency, was shared with others, but there is no evidence that it influenced all the work with Lauren.

4.49 Lauren had many health issues. Her GP saw her for her annual learning disability health check, but this appears to have been separate from the CiN processes and CP plans.

4.50 Lauren was provided with an advocate to help her express her needs in the CP conferences that started in April 2017. It is unclear the extent to which this work made use of the existing cognitive assessments to ensure that this process was understandable to Lauren. Lauren also attended a number of conferences, and it remains unclear what action was taken to ensure that the language used in the conference was understandable; it seems unlikely that she was provided with an easy read version of any of the conference reports.

4.51 Consultant Paediatrician 2 saw Lauren regularly with either the youth worker or the family support worker. He adapted his language to ensure that Lauren understood and he followed this up with a letter after appointments in language that was understandable. He organised for the youth worker to spend time with Lauren preparing questions she had about her health needs and used these to provide Lauren with clear health information that she wanted to know about. In this meeting the youth worker prepared a "thumbs up" and "thumbs down" so Lauren could indicate what she did and did not understand. This was effective child centred practice which took account of Lauren's disabilities and individual circumstances. It was a good example of giving her some control in circumstances where she had little control in other areas of her life.

4.52 In January 2018 there was a practice audit of the service response to Lauren. This raised significant concerns about drift and delay, and the lack of action to safeguard Lauren. The head of service recognised that account needed to be taken of Lauren's learning disabilities. This was effective practice and led to a mental capacity assessment and a further cognitive assessment. The Mental Capacity Assessment (MCA) found that Lauren did not have the capacity to consent to sexual activity. This led to appropriate disruption action by the Police, but did not change the professional narrative of Lauren making a choice to meet men. This knowledge was not integrated into the plan, and ultimately for a while professional evaluated the risks to Lauren having lessened from this point onwards. This was evident in the discussions between SW7 and her manager in August 2018 and review case conference that took place in September 2018. The MCA should have highlighted that she was at increased risk and more dependent on advice and support at home.

4.53 A further cognitive assessment was undertaken in March 2018. This was focussed on Lauren's capacity to engage with possible care proceedings, but also confirmed the significant level of her learning disabilities. This report both acknowledged these disabilities, lack of capacity to consent to sexual activity and suggested that she would need to be taught to say "no"; a complete contradiction which was not picked up by those receiving the report.

4.54 The CAMHS worker received this report in September 2018; he made sure that it was shared appropriately and that this outline of Lauren's cognitive needs should inform the assessment being undertaken by the adult learning disability team. This was appropriate.

4.55 There was a mixed picture across this review of the extent to which professionals understood Lauren's learning disabilities, respected that they were part of her individual identity and made adjustments to ensure that she had a chance of understanding and taking part in all the different services and professional working with her. In many agencies records it was just recorded that Lauren had a "*mental age of 8 to 10 years*" without any further analysis or action. There were good individual responses from some professionals, which was likely undermined overall by the lack of a coordinated approach. Lauren worked with many different professionals and there were many changes over the 3 years; this would have been very confusing for her.

4.56 Lauren was also an adolescent with learning disabilities who was heading into adulthood. A consideration of what help she needed to make that transition successfully was required; alongside this she was a vulnerable child and was to be a vulnerable adult. Some thought was also needed regarding this transition as a disabled person. There were discussions in January 2018 regarding this (when she was 16) but there was continued drift and delay and this was only actioned when she was nearly 18. Lauren's learning disability and the action necessary to promote her well being got lost in all the other concerns that professionals had.

There are two key issues to address here:

- The ability of non-specialist safeguarding and welfare professionals (including the Police) ability to recognise the needs of a child or young person with a learning disability, think about what this means for the child or young person, and implications for the work to be completed with that young person. It is not good enough to record that a child "has a mental age of 7". This is both disrespectful to the child or young person and is outside of the requirements of both the Equalities Act 2010[35] and the Disability Discrimination Act 1995[36].

[35] https://www.gov.uk/guidance/equality-act-2010-guidance
[36] https://www.legislation.gov.uk/ukpga/1995/50/contents

- There was insufficient Transition planning for Lauren

Recommendation 2: The GSCE should ask core agencies involved with Lauren to undertake an Equalities Impact screening of their current service offer to assess the extent to which it effectively addresses the needs of learning-disabled children and young people not known to specialist services.

Recommendation 3: The GSCE may wish to develop guidance regarding best practice in working in a child centred way with children and young people with learning disabilities who receive services from non-specialist agencies.

Recommendation 4: The transition planning from children to adult social care services was not effective. It is not clear if this was just an issue for Lauren or there are wider concerns about transition planning. The GSCE should seek further information to evaluate what action needs to be taken in this area.

Finding 3: Recognising, assessing and responding to adolescent neglect

Adolescent neglect is defined as "persistent and pervasive failure by a parent or parent figure to meet an adolescents physical, emotional, educational, medical and safety needs; causing harm to their health and development and increasing their vulnerability to all forms of exploitation, increasing possible engagement with risky behaviours such as substance misuse, sexually harmful behaviours, anti-social behaviour, crime and increasing the likelihood of poor mental health and wellbeing. It may be deliberate or not"[37]

4.57 Adolescence is a time of great emotional, physical and cognitive change. Adolescents need appropriate parenting and research suggests where neglect is ongoing during this time the outcomes are connected with poor mental health, criminality, self-harm and vulnerability to exploitation amongst a range of other negative outcomes. There was considerable evidence of historical neglect of Lauren and her sister which was across their whole childhood and of neglect into adolescence. Where there has been this cumulative level of emotional and physical neglect children go into adolescence without the frameworks or emotional structures to enable them to manage the demands of this developmental stage. This is not their fault and these structures need rebuilding. This analysis did not form a part of the ongoing child in need or child protection plans.

4.58 There are six key questions to be considered when assessing and addressing neglect and indeed these questions are the basis of the existing GSCB neglect toolkit:

1. Persistence
2. Type of neglect including:

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- Physical
- Emotional
- Educational
- Medical
- Supervisory
- Is it global: concerns in all developmental areas?

3. Impact and lived experience of the child; what does the neglect mean for them
4. Causal factors
5. Omission or commission
6. Other abuse that the neglect is enabling

Each question provides a picture of the neglect, how pervasive it is and what action in each area is needed.

Persistence and evidence of cumulative harm

4.59 Lauren and her sister had experienced neglect which was cumulative and pervasive throughout their childhood. This was known by most agencies and was covered extensively in the assessment completed in April 2016 by GCSC. This historical neglect was recognised, but there was little analysis of what this meant for Lauren's overall well-being and her transitioning into adolescence. Some of her physical health needs were caused by historical neglect; certainly, some of her emotional health outcomes such as self-harm, anger and need to be liked and wanted would be connected to this long-term experience of neglect. Her cognitive skills would also likely have been impacted. The impact of this early neglect would have left her unprepared for the transition into adolescence and impacted on her ability to cope and be resilient in the face of the demands of this new developmental stage. Yet the narrative was on her as an individual, not a child who had not been cared for.

Type of neglect

Physical care:

4.60 The Family Support Worker noticed that Lauren had few personal care skills, and spent time teaching her those. There was no discussion of why she did not have these skills; what had been the gaps in parenting. The School Nurse and GP noted that Lauren looked unkempt and there were times when she had untreated headlice. There were times when Lauren shared with professionals that she was hungry, and although this was addressed the meaning of it was not explored and not connected to this being parental neglect. The FSW witnessed Lauren setting fire to her hair whilst trying to cook and not knowing what to do,

Education:

4.61 In 2016 Lauren started to withdraw from education, and it is unclear the extent the role father played in this. It is unclear the extent to which father engaged in school feedback sessions, though he did attend meetings.

Health:

4.62 Father did attend health appointments, but for much of the years 2016 to 2019 a range of support workers attended appointments with Lauren and facilitated her attendance. Father suggested this was more appropriate because she was a young woman, but meant he did not have to demonstrate commitment to making sure she attended. The FSW did find hundreds of unopened health appointment letters in the family home.

Emotional care:

4.63 Father was clear that he was a reluctant parent and refused to attend any parenting programmes. It is quite hard to get a picture of the emotional relationship between father and Lauren because this is not provided in records. Lauren did tell the psychologist in 2018 that no one loved her and she consistently told professionals that sending explicit pictures and meeting men was because she wanted to be loved and liked; there was no analysis of how this connected to her experiences of parental emotional care. It was clear that he was focussed on his own relationships and either left Lauren in the care of her sister and her partner or on her own; a very lonely existence for her.

Supervision:

4.64 Father provided little supervision. He was often not at home, and Lauren believed that he did not care who she was with. Mother also provided little supervision which was a critical issue for Lauren.

A detailed understanding of these five areas was required.

Impact of neglect

4.65 It is also important to consider what impact parental neglect is having on a child or young person. There are real dangers that the impact of neglect in adolescence becomes focussed on the child or young person and they then are seen as the problem. There was a very clear impact of the neglect that Lauren experienced. She struggled to regulate her emotions and was described as being angry and aggressive. In 2016 when she had been raped, and was being left alone by father and rejected by mother, the analysis was on what was seen as her problematic behaviour. This led to the diversion from care team to be involved. The analysis was that teenage behaviour could cause family breakdown. Rather than adolescent neglect was having an impact and that was what was needed to be addressed. It was accepted that father refused to attend parenting classes, whilst continuing to sight Lauren as the

problem. Over time many professionals became concerned about incidents of self-harm and depression. Referrals were made to CAMHS and Lauren was consistently found not to have any form of mental disorder. The analysis needed to have been on the corrosive impact of the emotional neglect she was experiencing and what would be helpful to address this.

Causal factors

4.66 If the neglect of children and young people are to be addressed, there needs to be a clear analyse of why it is occurring; what is causing it. In historical terms there was evidence of mother's poor mental health and alcohol misuse, alongside father's domestic abuse. In the period 2015 to 2019 there was no focus on the neglect, and therefore no analysis of why father was neglecting Lauren's needs. Without this analysis there was no plan to create change.

Omission or Commission

4.67 Professionals need to think about whether the neglect of a child is an act of omission or commission. Neglect is often assumed to be an act of omission with parents /caregivers struggling to provide effective care because of their own impoverished and deprived circumstances. This is very often the case and this knowledge provides a pathway to appropriate support and intervention. However, for some parents or caregivers neglect is an act of omission; they take no responsibility for the quality of care they provide and are often hostile or dismissive to advice or interventions. The lack of responsibility on the part of parents often tips into blame. Children and young people are held responsible for the poor-quality care they receive, with parents citing their young people as too difficult or too damaged to care for and this attitude has a powerful impact on young people's lives. Father did suggest that Lauren was too difficult to manage and that he could not cope with her behaviour. He refused help to address this. This is a cognitive catch 22 for children and young people. The neglect they experience causes a negative impact, and this is then cited by a parent as the reason why they cannot parent well. Children and young people do not get the care they need, and then are held responsible for that lack of care. Children and young people can be referred to as damaged rather than living in damaging circumstances. Language here matters. This has extremely negative consequences on their wellbeing and future outcomes and needs to be addressed. There was evidence that father knew of the sexual abuse that Lauren experienced and did not intervene. This needed clearer challenge.

What other kinds of abuse was the neglect enabling?

4.68 Research has shown that there is a strong connection between child and adolescent neglect and sexual abuse and exploitation. This is a complex relationship which requires assessment and analysis of an individual child and their family

circumstances. This did not happen for Lauren but more thought and discussion could have been had about the poor emotional care she received in her adolescent years, her assertions that no one loved or cared for her, and those that groomed her seemed to be paying her the attention she needed.

4.69 Adolescent neglect was an important issue here which was not articulated or assessed. It is a complex area of work which requires professionals to be skilled and trained, with the appropriate tools and frameworks. This review of Lauren's circumstances concurs with the conclusion of the recently published SCR Liam by Gloucestershire LSCB. The multi-agency partnership response to adolescent neglect needs to be strengthened to ensure practitioners are competent and confident in identification of adolescent neglect and working with all aspects and types of neglect including assessment of parenting capacity, motivation to change, sustainability of any improvements. Impact on child and young person and parental/care attitude to the parenting task

Recommendation 5: The GSCE needs to assure itself that the planned refocus on the GSCB Neglect Strategy, procedures, single agency training and multi-agency training programme results in demonstrable improved outcomes for children living in neglectful circumstances.

Finding 4: Understanding Relational and Developmental Trauma; the importance of professional recognition that this causes increased vulnerability to children and negative impact on children's lives

"The impact of early neglect and trauma can cross every area of children's lives, negatively affecting their capacity to…develop a moral sense…and make close, trusting relationships."

4.70 This finding focusses on the professional understanding of the impact of developmental and relational trauma on Lauren and her circumstances specifically, but also other children and young people locally. Lauren experienced trauma in childhood in a number of ways. She lived in a household where father was domestically abusive to mother. She was taken out of school, and moved home, away from friends and family. She was raped and sexually assaulted on many occasions. With father seemingly uncaring about the impact for her and with some evidence that he might have played some part in introducing her to men. She experienced developmental and relational trauma. This was not part of the thinking about her circumstances and connects clearly to the issue of blame in neglect.

4.71 There is significant evidence regarding the negative long-term developmental effect of abuse and neglect of children by their primary caregivers or family members. This relational trauma, which takes place in the context of family relationships, is fundamentally different from single incident trauma where experienced by children

who were previously coping and developing appropriately. Children's early relationships and interactions with adults are essential to provide the organising framework and representational models for children's future relationships. Their developing sense of the world, sense of self, personality is grounded and moulded through these foundational relationships. Through these relationships children come to understand and make sense of their own inner worlds, how other people act and react in social encounters. Essentially, the quality of these early relationships is key to guiding a child's identity, expectations of self and others, their self-esteem and self-concept.

4.72 Children who have experienced parenting relationships and an emotional milieu characterised by fear, anger, hostility, pain, intrusiveness withdrawal and disengagement learn to see others either as a threat or a source of alternative comfort. Children are left without a template for positive and appropriate social and emotional interactions. Contact becomes a source of stress and anxiety. In order to survive, children have to develop survival skills and powerful defence mechanisms to protect themselves from further pain and loss. Their ability to assess safety and danger becomes skewed, and they often have difficulties understanding other peoples' feelings behaviours and intentions. The legacy for these children is that they are often fragile, wary, anxious, depressed, angry, emotionally vulnerable and struggling to make healthy relationships.

4.73 This makes developmental transitions more difficult. Adolescence is a time of considerable biological, psychological and social change and consequently the transition from childhood to adolescent can be difficult[ix]. Adolescents who have experienced early trauma and abuse and whose family and social circumstances are complex have not always been equipped with the skills and emotional repertoire to manage this transition and can thus find it more difficult[x].

4.74 These difficulties are not always then perceived as a result of those early experiences or current family difficulties, but as a problem with, and of, the adolescent. Research[xi] and SCRs[xii] have highlighted that because adolescence is a time of independence that when adolescents become known to services there is a tendency for professionals to evaluate their difficulties in isolation and they can become seen as "troublesome" rather than "troubled by their circumstances" and there can be a lack of understanding that behaviours and responses to the world are a manifestation of trauma, not a manifestation of adolescence or individual problems.

4.75 There was considerable evidence of how the relational and developmental trauma impacted on Lauren. She demonstrated anger and aggression at home and at school. She self-harmed and she went into situations where she knew there was some level of risk that an individual would take advantage and assault her. Professionals needed to see Lauren's responses as a manifestation of trauma and severe neglect. If this is

not acknowledged, there is a danger that children and young people see themselves as the problem that needs fixing through attendance at CSE education sessions, or support through CAMHS, or helping parents to manage their difficult behaviour. This analysis might have been complex for Lauren to understand, but the message that this is not about "what is wrong with you" but about "what has happened to you" might have been helpful in building her resilience and addressing her sense that she was not loveable. She had just not been loved. This message is important to all professionals working with adolescents: they need a good understanding of relational and developmental trauma as a frame of reference to understand children's lives.

Recommendation 6: Multi-agency partners of the Gloucestershire Local Safeguarding Children Board (GSCB) have already made a commitment to a trauma informed and restorative approach to practice, informed by the learning from ACEs. The findings from this review of Lauren's circumstances needs to inform the ongoing development of a trauma informed approach and the GSCE should satisfy themselves that this would make a difference to the service response to young people like Lauren.

Finding 5: Dealing with professional disputes and differences of opinion in ways that out the child and young person at the centre.

4.76 It is inevitable that there will be professional disputes and differences of opinion given the complexity of safeguarding. What is important that these difference or disputes are addressed in a child focussed way. Research and serious case reviews have highlighted that differences of opinion and professional disputes are not always handled effectively to the detriment of a child or young person.

4.77 The school Lauren attended raised early concerns about her from 2015 until she left the school in 2017. They expressed clearly their unhappiness with decision making by GCSC and the drift and delay in the action being taken. They particularly felt that Lauren should have been subject to child protection processes from March 2016, and this view was shared by other agencies. The school sought advice from the GSCB and their concerns were successfully taken up by senior managers. The psychologist and ISVA also made clear their concerns. This led eventually to Lauren becoming subject to a child protection plan for neglect. This demonstrated that safeguarding partners across the safeguarding partnership have an awareness of the existing escalation process and their ability to focus on the needs of a child.

4.78 In December 2017 senior managers in GCSC became aware through an audit of Lauren's circumstances that there had been drift and delay in planning for her and this was raised with the responsible managers. This also led to further action and a legal planning meeting. It is of concern that once this initial scrutiny was gone,

concerns about how well Lauren was being safeguarded diminished. It took a new social worker and child protection chair in late 2018 to raise the lack of progress.

4.79 There is some evidence that these escalations were taken personally by the individual social workers and team managers involved. It is always hard for a professional to be told that their analysis and approach is not addressing the needs of a child. The escalation process and the normality of these differences occurring in complex cases should help to see this not as individual criticism but making change in the best interests of the child. It appears that these feelings of personal criticism by individuals and their managers meant that their views became more entrenched, and that they did not accept this new analysis. This is certainly clear in the period after the audit. Legal planning processes were initiated, but after a six-month period they were halted. There was little evidence that Lauren's circumstances had changed, that she was any safer or that father had taken any steps to improve his response.

4.80 This highlights the need to address personal feelings of criticism in the context of the escalation process and for there to be a complex case meeting to discuss a new analysis. The escalation process has not worked if the differences of professionals' analysis have not changed. The process may have changed, but the view of what is happening for the child has remained the same. This happened here.

4.81 Work has already been undertaken regarding the GSCB escalation policy which has been simplified and training provided to all agencies including schools and Senior Managers in GCSC. However, this review concurs with the view of the recently published SCR by GSCB about Liam[38] which suggests that more needs to be done to promote the role of escalation in partnership working together with respect and mutual understanding of others' roles and responsibilities and understanding of the limitations in practice. There should be a focus on restorative practice principles that foster and enhance partnership working and a culture where respectful professional challenge is productive and welcomed.

Recommendation 7: The GSCE to undertake work to promote the role of escalation in partnership working in the context of respect and mutual understanding of others' roles and responsibilities. There should be a focus on restorative practice principles that foster and enhance partnership working and a culture where respectful professional challenge is productive and welcomed as the voice of a 'critical friend'.

Finding 6: The operation of routine support and safeguarding processes for Lauren

4.82 The terms of reference for the IMRs produced as part of this review asked specific questions about decision making, assessments and child protection plans. It is clear

[38] https://www.gscb.org.uk/media/2098723/scr-0319-liam-final-20200430.pdf

that these did not work well for Lauren. The routine child welfare and protection processes were ineffective.

4.83 There were a number of overall assessments undertaken over a three-and-a-half-year period. These were either under the auspices of the child in need framework or child protection. They consistently lacked robustness, analysis and a focus on CSE or neglect - the two key issues that were important for Lauren. At times the assessments were cut and posted from previous versions and were not child centred. The voice of Lauren and Jem was not clear, and Lauren's learning disability not analysed. The focus should have been on father and mother's responsibility for providing care and protection. The assessments were also an opportunity to consider Lauren's reluctance to engage with the Police and disruption of the perpetrators of sexual exploitation activities. The primary statutory responsibility for undertaking these assessments lies with GCSC and concerns about the quality of assessments was a message from the last full inspection of children's services and addressing the quality of assessments is part of their improvement plan. The multi-agency group also has a part to play. These assessments should be shared with all agencies working with a child. If these assessments do not address the core issues this needs to be challenged. Agencies could have challenged the quality of the assessments as they related to Lauren.

4.84 Lauren was a Child in Need for a period of one year. This is an important process with the Children Act 1989 making it clear that the health and development of this group of children will continue to be impaired without a clear CiN plan; which addresses the key concerns; provides services which address those concerns; sets goals and which is reviewed to ensure progress or address the lack of it. The first single assessment within the period under review was undertaken in April 2016. There was a plan of action outlined as part of the conclusion of the assessment, which was not made into a CiN plan. This meant there was never a CiN plan formulated for Lauren and her family. There were regular CiN reviews, but they were used to feedback what had happened in the period since the last meeting. These meetings did not have an overview or consider the cumulative harm. There was no reviewing process, because there was no plan. These meetings were well attended and included all those concerned about Lauren and one meeting enabled the multi-agency group to pull together a comprehensive picture of concerns in November 2016. This still did not lead to a formal CiN plan.

4.85 It is of course clear that it was inappropriate for Lauren to be considered in need of support, rather than in need of protection, but nevertheless an appropriate CiN plan with goals, intended outcomes and services targeted at concerns could have contributed effectively to supporting Lauren. It is the primary statutory responsibility of GCSC to develop an appropriate child in need process and there is clear guidance locally regarding this. Poor child in need processes have been a concern in a number

of Gloucestershire SCRs and were also highlighted as an issue in the last full Ofsted Inspection. This is part of the current improvement plan. It is also important that all agencies that are part of a CiN plan advocate on behalf of children, by noticing the lack of a plan, with appropriate services and goals, and do something about this. This did not happen for Lauren.

4.86 There were many strategy meetings/discussions held over the three and a half years reviewed. There were times they should have been held and were not. They lacked health input, given the concerns about sexual abuse and exploitation and they were not always child focussed. Lauren's learning disability, for example, was discussed, but no plans were made to take account of this in keeping Lauren safe. Each strategy meeting was viewed in isolation; there was no sense that anyone involved highlighted that this was the 4th/5th/6th 7th strategy meeting (and so on) and therefore considered what that meant both about the effectiveness of current planning or the safety of Lauren. These meetings are intended to come up with a plan to keep a child safe. There was too little discussion about how criminal procedures dovetailed with CiN/CP processes, how those criminal procedures could be maximised by addressing Lauren's inability to take part, and father's lack of responsibility to ensure that all was done in this area. These meetings did not also serve to discuss disruption tactics until October 2018. Again, strategy meetings form part of the improvement plan for GCSC. They also need to be part of a review process for the Police to see how their work can be incorporated into the child welfare processes.

4.87 Lauren was subject to a CP plan for two years. It is not clear what this plan was hoping to achieve. The service response was remarkably similar to those delivered under the CiN process. Lauren continued to be targeted and abused, but there was a lack of analysis of the grooming and predatory behaviour of the men who were assaulting her, a lack of acknowledgement of neglect generally, and emotional neglect and abuse specifically and mistaken sense that Lauren could be either taught to "say no" or "not meet me" or be supervised at home and have her phone removed. This was not the right plan. This should have been noticed by managers, the chair of the conferences and the multi-agency group and challenged. There were times when concerns were expressed about the quality of the CP plan and the lack of progress of its limited goals, but this did not lead to any real change. The primary statutory responsibility for the quality of child protection meetings and plans lies with GCSC and creating change around these processes is included in the improvement plan. It is also the responsibility of all agencies to notice when child protection processes are not being effective for a child and take action to address this. This is to be an advocate for a child and in this case an advocate for Lauren,

4.88 There was a lack of urgency in the responses to Lauren's needs from the children and adult legal team, which replicated the delay in taking timely and authoritative action

across the previous three years of involvement. This lack of urgency needs to be addressed. The legal teams were provided with verbal information from social workers and their managers to help them to provide effective legal advice. They should have been provided with a chronology and an analysis of all concerns. For Lauren this meant the legal team did not understand the seriousness of her circumstances, the extent of the harm she was experiencing, caused by the lack of safety from father. The legal team in turn provided advice that the legal threshold had not been met to take action to safeguard Lauren. This caused frustration to the social workers and their managers; yet the advice was accepted without challenge or an escalation of concerns. Those managers and social workers could simply have gone back to the legal team and explained that they may not have made clear the seriousness of the concerns regarding Lauren and been prepared to provide more information and analysis in writing. There is current work underway to address this in GCSC.

4.89 The failings of routine safeguarding and support practices with children's services had a profound impact on the lack of safety and prevention of harm to Lauren. There were times when multi-agency partners did recognise that these routine processes, which are the responsibility of children's services, were not happening as they should do and there was appropriate challenge. There were though times when agencies did not notice the lack of effectiveness of assessment, planning, meeting and review processes. The basics do matter. It is the responsibility of children's services to deliver these, and for multi-agency partners to support them to do so and to notice when things go wrong,

These failures to provide the basics of the safeguarding system to Lauren and her family need to be seen in the context of the Ofsted Inspection[39] published in June 2017 which highlighted many of the issues present in Lauren's case. There is an improvement plan in place which speaks to the concern in this finding.

Recommendation 8: The GSCE will need to be assured that the current improvement plan for Children's services delivers change that will make a difference to children like Lauren and this this work is being done alongside multi-agency partners as critical friends.

[39] https://files.ofsted.gov.uk/v1/file/50004377

5. Conclusion

5.1 Lauren was a child of 14, with a learning disability which often went unrecognised; she was severely sexually abused, exploited and assaulted over a three-year period. It is important to recognise that the considerable sexual, physical and emotional harm that Lauren experienced was caused by a large number of predatory males and it is important that this is both recognised and acknowledged; something that was not consistently the case for Lauren at the time.

5.2 Lauren could also reasonably have expected to be cared for, nurtured and protected by her parents and wider family. There is considerable evidence that this was not the case by her parents; there is little information available about the wider family and their relationships with Lauren. She experienced early neglect from both her parents with long term impact on her emotional and physical well-being. There is also clear evidence of the ongoing neglect of her adolescent needs, particularly for safety, love and advice. Her father did not keep her safe from sexual abuse and did not comply with advice from agencies which might have helped.

5.3 Safeguarding children is also the responsibility of public authorities and it is clear that the safeguarding systems and processes in Gloucestershire failed to keep Lauren safe from harm over a three-year period. The reasons for this are complex and are not associated with the actions of any one individual or agency alone. There is much evidence that many of the professionals involved with Lauren worked hard to provide support and endeavoured to find ways to protect her. It is never one factor that leads to the failure to ensure the safety of a child. For Lauren there were weaknesses in the multi-agency responses to child sexual exploitation, including disruption and particularly worrying victim blaming attitudes that got in the way of ensuring she understood that she was not responsible for the severe sexual abuse and assault she experienced. Her learning disabilities were not understood and this exacerbated these problems alongside the impact of her experiences of neglect and trauma. Alongside these complex factors which interacted negatively and cumulatively over time, the basics of the child in need and child protection system were not in place.

5.4 There is no simple solution to the complexity of child sexual abuse and exploitation, but a focus on the perpetrators of this abuse, their persistence and grooming of those who are vulnerable in our society is necessary, and a recognition that this is an issue that needs addressing early on. Waiting for the harm to happen, and then trying to address an already entrenched pattern of predatory male behaviour does not work. Blaming the victim does not work. Lauren was not responsible for the considerable harm she experienced, and this review and others like them are an opportunity to reflect on how to improve the response to child sexual abuse and child sexual exploitation.

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