Torbay Safeguarding Children Board

Safeguarding Children Board

Serious Case Review C74

Sexual Exploitation Disclosed: 16th March 2018.

Author: Paul Northcott

Date review report completed – 19th December 2019.

C74 has been described as an intelligent, determined and mature young person who has been incredibly courageous throughout the investigation into her exploitation. As the author of this document I would like to thank her for meeting with me and for being honest and open about her experiences. This cannot have been easy to do.

Contents

1.0 Introduction

1.1 This is the serious case review report of an incident involving C74 (victim), which was commissioned by the local Safeguarding Children's Board. This review examines agency responses and support given to C74, and her foster carers prior to the disclosure that she made about a sexually exploitive relationship with a Child and Adolescent Metal Health Services (CAMHS) professional. This disclosure was made by C74 on the 16th March 2018.

1.2 The key purpose for undertaking the review is to;

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

1.3 The focus of this review has been agreed from March 2017 when C74 was hospitalised following an overdose. This incident initiated regular contact for C74 with the CAMHS crisis team. It was agreed that the time period will end in April 2018 when it was established that CP4 had continued contact with C74 after his release from custody by mobile phone and was remanded.

1.4 The specific lines of enquiry identified to focus the Serious Case Review are:

1 To gain an overview of C74's care arrangements, family dynamics, significant events and relationship and the impact of these on her identity and development.

2 To analyse how well C74's individual needs and vulnerability factors were recognised and addressed in the assessments, interventions and care plans that were made to support her.

3 To analyse critical incidents during the review period and comment on the quality and effectiveness of intervention and service delivery at this point and the impact for C74.

4 How well did C74 respond to the services that were offered to her? What was the quality of individual professional interaction with her and how well did she engage with individual professionals? Were C74's voice, views, wishes and feelings sought and captured in their work with her?

5 Did the arrangements following CP4's arrest suitably safeguard C74?

6 To evaluate whether the arrangements within the employing agency were sufficiently robust and how effectively were they followed.

7 When C74's pregnancy was known, what work was undertaken by professionals with her to explore the circumstances through which she became pregnant and the identity of the punitive father?

1.5 In addition to agency involvement this review has also sought to examine relevant background information. By taking a holistic approach the review has attempted to identify learning from the case that will hopefully make the future safer for children and young people.

1.6 Every effort has been made to conduct this review process with an open mindset and avoid hindsight bias, and any other bias toward any one agency or individual involved.

2.0 Summary

2.1 C74 had been living with her foster parents and was the second eldest of five children. She had one natural sister, one half-sister and two brothers who were adopted 2016. Three of the children had lived with their mother (MOC), who was aged 33yrs, until June 2015 when they were placed in Local Authority Care following a domestic violence incident. The family were known to services due to long periods of instability and neglect.

2.2 C74 was placed into the care of the Local Authority on 8th June 2015, aged thirteen, and a full care order was granted on 10th December 2015. There has been extensive involvement within Child Protection and Child in Need processes which had spanned many years of C74's life.

2.3 Between 2012 and 2014 various core groups and child protection reviews were held due to the children living in a chaotic and abusive family. The family dynamics were also compounded by the complex relationship between C74's mother and the different fathers of the children.

2.4 In October 2016 C74 became involved with the CAMHS crisis team following episodes of self-harm and suicidal ideation.

2.5 On 16th March 2018, C74 made a disclosure to the vice principal and designated safeguarding lead at her college that she was being abused by CP4.

2.6 At the time that this disclosure was made C74 was sixteen years old. C74 disclosed that this abuse had started when she was fifteen (just before the Christmas of that year). The abuse had then continued over a number of months.

2.7 C74 disclosed that the abuse had resulted in her becoming pregnant and that CP 4 had encouraged her to have a termination. Following that manipulation C74 felt that she had no option but to have a termination in February 2018.

2.8 CP4 was subsequently arrested on the 16th March 2018 and again on the 18th April 2018 (perverting the course of justice). CP4 was convicted on the 5th December 2018 of the offences of sexual activity with a child under sixteen (no penetration) and sexual activity with a person with a female with a mental disorder (with penetration). His sentence was increased to 11yrs 6 months on appeal.

3.0 Timescales

3.1 This case was considered at the local Serious Case Review (SCR) Subgroup on the 2nd May 2018. Following careful consideration of the SCR criteria, (as set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006), the Independent Chair of the local Safeguarding Children's Board was satisfied that there was evidence to support the threshold for 'serious harm' (Working Together 2015). This decision was supported by the National SCR Panel on the 12th July 2018.

3.2 The review commenced on the 15th January 2019.

3.3 The review concluded on 19th December 2019.

3.4 The completion of the report was delayed due to the criminal investigation process and a Crown Prosecution Services decision to appeal against CP4's sentence. Once this process had been successfully concluded the review process was able to continue. A further delay occurred as C74 wanted to meet with the report author and due to her fragile mental state this took some time to facilitate.

3.5 An additional delay occurred in securing independent advice in relation to CAMHS practices and policy.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating agencies and the appropriate professionals within them.

4.2 The content of the report has been anonymised to protect the identity of the victim, perpetrator, relevant family members and all others involved in this review. The pseudonym/s are as follows;

- Victim – C74.
- Perpetrator (CAMHS practitioner) – CP4.
- CAMHS Crisis support worker – CP2.

- CAMHS Crisis support worker – CP3.
- CAMHS Tier 3[1] support worker – CP5.
- C74's Social worker – SW1

5.0 Methodology

5.1 Following the decision to undertake the review all relevant agencies were requested to check their records about any interaction that they had with C74 and CP4.

5.2 Where it was established that there had been contact the Board ensured that all agencies promptly reviewed relevant documents. These agencies were then asked to provide a chronology detailing the specific nature of that contact.

5.3 The local Safeguarding Children Board appointed Paul Northcott as the independent author of the management review report on 21st October 2018 (see Appendix A).

5.4 Each agency's chronology covered details of their interaction with C74 and CP4, and whether they had followed internal procedures.

5.5 The following agencies supplied chronologies;

- Police.
- Health - The local NHS Foundation Trust (Hospital and Community), GP, The local Partnership Trust.
- Children's Services.
- Education.
- CAMHS.
- Safeguarding and Reviewing Service

5.6 On request some agencies provided additional information to clarify any issues that were raised. This additional information included;

- Agency policies and practice documents.
- Minutes of all social care meetings, risk assessments.
- Policies and procedures.
- Foster Carer weekly recording sheets

5.7 As part of the process key professionals who were personally involved with C74 were individually interviewed by the report writer.

5.8 A Panel was also established to look openly and critically at individual and organisational practice to see whether the case indicated that changes could or

[1] Tier 3 services are usually multidisciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders.

should be made to agency policies and practice, in order to improve the frontline delivery of services. The panel consisted of the following members;

- Assistant Director, Children's Services
- Designated Nurse for CLA, NHS [Local] CCG
- Safeguarding Business Manager
- DSL, Independent Secondary school
- Detective Chief Inspector -Police

5.9 Advice regarding CAMHS was obtained from a senior manager from that organisation based elsewhere in the Country.

5.10 All previous SCR's and the relevant action plans were also reviewed to identify reoccurring themes and whether the lessons learnt had been acted upon within the local area.

5.11 In view of the fact that C74 was a young person within Care and the circumstances in this case the panel decided that there was no requirement to approach her family.

5.12 C74 was spoken to as part of the review process and her thoughts and experiences have been included in this report.

6.0 Equality and Diversity.

6.1 This review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re- assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the report writer as part of the terms of reference and throughout the review process.

6.2 C74 was a white British heterosexual national. CP4 was of African dissent.

6.3 The religious and philosophical beliefs of both the C74 and CP4 are not known but there has been nothing identified as part of this review that would indicate that such beliefs impacted on their life choices or the services that they received.

6.4 No barriers to accessing services in relation to inequality were identified.

6.5 The review process found no evidence that C74 or CP4 were directly discriminated against by any individual or agency based on the nine protected characteristics.

7.0 Background Information (The Facts)

7.1 C74 had come from a complex family background. Her mother was described by agencies as living a chaotic lifestyle with deteriorating mental health issues and there were periods when she was difficult to engage with. C74's mother had a history of trying to take her own life and was known to abuse substances.

7.2 C74's mother had been involved in a number of relationships and had been the repeat victim of domestic abuse. C74 and her siblings had witnessed some of these abusive incidents (Police records) and there was evidence of neglect in the family (Social Care records). C74 had stated that she was the victim of violence[2] on numerous occasions whilst living in the family environment. C74 had no contact with her natural father.

7.3 Multi Agency intervention had spanned many years of C74's life resulting in child protection and child in need (CIN) intervention. Between 2012 and 2014 various core groups and child protection reviews were held to assess the needs of the family. Due her exposure to domestic abuse C74 had attended a children's domestic violence support group in 2012.

7.4 As a result of the concerns about C74's mothers' inability to effectively care for her children the family were initially supported through the CIN process (open to social care since August 2011) and then through formal child protection procedures.

7.5 C74 has been described by those professionals that worked with her as a bright and articulate individual with a great sense of humour. C74 would like to watch films, use the internet and she desired gaining her own independence. C74 had worked in part time in a café and guest house and demonstrated that she had the social skills to competently interact with her peers and adults.

7.6 C74 did not to attend regular classes and instead would go to a designated area within the college where she was supervised by people that she had leant to trust. Those that supported her at the college describe her as being academically able and she would consistently meet the targets that were set for her. C74 enjoyed reading and was extremely good at art.

7.7 There were periods in C74's life when she did enjoy some stability (College Health records 2015) but there were many other occasions where she would become overwhelmed by the complexity of her life. This led to C74 reacting in ways that professionals found difficult to understand and her committing acts of self-harm.

7.8 C74 had been living with her half sister and her step father (half-sisters father). She had then moved to live with a friend's parents whilst being assessed for a foster care placement. This arrangement broke down and C74 went to a foster placement with a view that she could possibly return home to her mother's care. C74 had therefore led a very transient lifestyle with no sense of permanency and had often been let down

[2] Child Progress Report(20/08/17)

by those close to her. All four of the younger children were subject to an interim care order.

7.9 C74 came into the care of the Local Authority on the 8th June 2015, aged thirteen and a full care order was granted on the 10th December 2015. On being placed into care C74 was separated from her brothers and sister who were accommodated elsewhere.

7.10 During her time in care C74 had moved placement three times in order to meet her emotional and psychological needs. In the period covered by this review Health state that C74 had significant mental health needs which had resulted in her self-harming, taking overdoses (detailed in the chronology at Appendix B). C74 also had ideations to take her own life on occasions as detailed in her assessments FACE risk profiles[3].

7.11 C74 was known to stockpile medication such as paracetamol and there were constant concerns by agencies that she was hiding knives and razor blades at her foster placements.

7.12 C74 had a care and risk management plan which had been regularly reviewed by those agencies that were trying to support her.

7.13 C74 has been described by her social worker as a 'home bird'. In her early college days C74 was described as having a good group of friends (Health records; 2012) but as she grew older these appear to have diminished. At the time that C74 made her disclosure she had no immediate friendship group either in or outside of college.

7.14 C74's carers have stated that in the main the only time that she actually left her home address was when she went to college or when she accompanied CAMHS practitioners. Health, Social Care and foster carer records document consistent concerns due to her behaviour and the fact that she was socially isolated.

7.15 C74 struggled to sleep at night (Health records dated 02/06/15 state she we often not go to sleep until 4am) and she would often use her laptop and watch DVD's.

7.16 The first contact that C74 had with CAMHS was in early 2012 when she was discharged following assessment[4]. The second contact was in 2015. The third contact occurred in mid 2015. The contact with CAMHS was sporadic until March 2017 when C74 was hospitalised following an overdose. Over the next ten months C74 regularly self-harmed with some of her injuries requiring hospital treatment. In the same period C74 also attempted to take her own life by taking an overdose on three occasions. This escalation in risk and behaviour meant that CAMHS intervention was required on a regular basis.

7.17 Health records[5] show that C74 was suffering from mixed anxiety and depressive disorder. As a result of this diagnosis she was receiving help and support through CAMHS. In order to assist in her recovery C74 was receiving medication for her

[3] The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.
[4] These dates are outside of the terms of reference but were included to provide a comprehensive background in relation to C74's involvement with CAMHS.
[5] Referral for access assessment into inpatient services for Children and Young People.

anxiety and depression. Health, social care and foster carers documents all identify concerns that on occasions C74 would not take her medication.

7.18 In September 2017 C74 was voluntarily admitted to a CAMHS tier 4 unit. At the time she was described as having 'a long history of deliberate self-harm' and 'presenting with high levels of suicidal intent triggered primarily by her social circumstances'. The conclusion reached at that time was that C74 'would not be able to be kept safe in the community'.

7.19 The deterioration in C74's health and behaviour at that time was attributed to the fact that she was unable to attend her brothers birthday. C74 had also become angry due to the fact that her bedroom had been searched against her wishes as agencies were concerned that she had been concealing medication.

7.20 CAMHS workers supported C74 throughout the period covered by the review and together with social care and education professionals they continually assessed her risk and the need for intervention through their crisis team.

7.21 C74 regularly attended college where she was also receiving a significant amount of intervention. C74 had the support of the college safeguarding team and daily interaction with specialist staff. She also had access to counselling within the college environment should she have wanted it.

7.22 CP4 was of black African decent and lived with his wife and two children in the area where he worked. CP4 would describe himself to his colleagues as a family man and he would often talk about his wife and eldest child. CP4 had been employed as an agency worker by CAMHS from April 2017 and had been working with C74 since June 2017.

7.23 CP4 had worked in a variety of professional roles prior to taking up the post in the local CAMHS office. He was registered with the Nursing and Midwifery Council and DBS checks were carried out in Scotland (where he had previously worked) and England. No issues were raised as a result of these processes.

7.24 CP4 had been initially employed in a role as a crisis support worker and during his time with CAMHS he had worked with approximately forty to fifty young people.

7.25 In terms of concerning behaviour there was nothing recorded in terms of safeguarding concerns. CP4 had been involved in an incident with a previous adult female colleague in another part of the country but this had never been reported to the police. This incident was later reviewed as part of the police investigation and was found to relate to inappropriate (but not sexual) behaviour towards the female concerned.

7.26 CP4 had been moved from the CAMHS Crisis Resolution and Home Treatment Team (CRHTT) to a Tier 3 multi-disciplinary team within the same location on the 26TH February 2018. This team was more office based than his previous position. This move had taken place due to supervision concerns (detailed in section 9.8).

7.27 From the disclosures that were made by C74 it would appear that the sexual abuse committed by CP4 started when she was fifteen years of age just before Christmas 2017 and her sixteenth birthday. At that time CP4 had lied about his age and had stated that he lived with his sister and had a girlfriend.

7.28 C74 stated that the two of them saw each other on a daily basis except for a one-week period when there was no contact at all (the reasons for this are not known). On occasions CP4 would see her unofficially when working and he even took her to his CAMHS office on one occasion and got C74 to hide under a blanket in his car to avoid detection.

7.29 This abuse resulted in C74 becoming pregnant. In February 2018 C74 felt that she had no choice but to have a termination. On that date C74 had walked into a sexual health clinic and asked professionals for help. C74 claimed that the pregnancy had occurred as a result of a relationship with a fellow pupil. C74 never disclosed who this individual was. C74 was persuaded by Health professionals to tell her social worker about the pregnancy and termination.

7.30 In order to ensure that her welfare needs were adequately met C74's social worker informed her carers of the pregnancy and together they supported her through the termination process.

7.31 On the 15th March 2018 C74 received a phone call from CP4's wife. At that time his wife believed that he was having an affair and had obtained C74's phone number from his mobile telephone. The following day C74 disclosed the abuse to the vice principal and designated safeguarding lead at her college.

7.32 Police arrested and interviewed CP4 on 16th March 2019. During interview he denied the allegations and was released pending further inquiries. Police then became aware that CP4 had again contacted C74. This was discovered following the investigation of his phone records which showed that there were three thousand two hundred and twenty-three text and calls between the two.

7.33 As soon as the Police identified that there was significant contact continuing CP4 was rearrested and remanded into custody for the offence of perverting the course of justice.

7.34 In December 2019, on the second day of his trial at Court, CP4 pleaded guilty to sexual activity with a child and sexual activity with a person with a mental disorder by a care worker between December 2017 and March 2018. CP4 was sentenced to seven years eight months. Following an appeal by the CPS and the Police, this sentence was increased to twelve years.

7.35 The Police were unable to find any evidence that CP4 had abused other young people.

8.0 Summarised Chronology of Events

8.1 A Chronology of events can be located at Appendix B.

9.0 Analysis

9.1 This part of the overview will examine how and why the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events and whether any shortcomings identified are features of general practice. The analysis section will address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted and identifies what would need to be done differently to prevent harm occurring to a child in similar circumstances.

9.2 This analysis considers the previous sections within this report, the content of the chronologies that were submitted by agencies, and the feedback that was provided in the meetings held in response to this review.

9.3 C74's vulnerability

9.3.1 As a consequence of her families inability to effectively care for her C74 had been placed into care. C74 had been in the care of the Local Authority since June 2015. Previous incidents which had led to this decision had included reported concerns of sexual abuse and C74 being exposed to violence by her mother's ex partners. C74 had therefore been exposed to a number of adverse childhood experiences which made her at risk of further abuse[6](as documented in risk profiles and the reviews carried out by Children's Social Care). These early life experiences also had an impact on her development in terms of her confidence, self-worth and her ability to trust adults, particularly males.

9.3.2 C74 was considered by Health services to have complex mental health needs (although C74 disputes this claim) and required therapeutic support. Health and Social Care records document that C74 was vulnerable in the following ways[7];

- Risk of self-harm through overdosing and cutting – Significant
- Risk of accidental self-harm- Significant
- Risk of suicide – Significant
- Risk of abuse/exploitation by others -Low

C74 was also known to suffer from anxiety and depression and concerns had also been raised by her foster carers in relation to her possibly having an eating disorder.

9.3.3 It was not clear in agency records why C74's risk in relation to abuse and exploitation was considered low in view of her significant mental health concerns and early exposure to adverse childhood experiences. In C74's case professionals should have considered the impact of all of her risks in terms of increasing her vulnerability to abuse. The assessments that were completed were considered to be ineffective in terms of their ability to consider and mitigate against such risks.

[6] Children's Society (2019)
[7] CAMHS Functional Analysis of Care Environments (FACE) Risk Profile.

9.3.4 Those that supported C74 at her college described her as initially being angry and resentful of her life journey. She was often open to outbursts of significant aggression and many of the trigger points that preceded this behaviour (as recorded in agency records) appeared to be in relation to the break down in foster placements or when she felt that she had been let down by those adults that she had grown to trust.

9.3.5 Those professionals that worked with her were however aware of this pattern of behaviour and it was clear from agency records and from the interviews that were conducted with professionals that they would actively work together to try and mitigate any associated risks at those times in her life. These risks and the action taken were clearly recorded and shared across agencies which is good practice.

9.3.6 C74 was known by agencies to suffer from low moods and depression as a result of her childhood experiences and had been prescribed medication to assist with her symptoms. Agency records (Health, Children Services) show that professionals were concerned that C74 had not taken her medication and this would have had an impact on her behaviour and mental health. On those occasions where such behaviour was identified professionals would work with C74 and her foster carers (action documented in foster carer weekly recording sheets) to ensure that she took her medication.

9.3.7 C74 was isolated from her immediate family and had no close relatives that she could turn to. Whilst she met her mother on a regular basis this would be 'at her [C74's] terms' (minutes from Children's Social Care meetings - 03/07/15, 09/09/15) and from the detail that has been recorded in agency records it would appear that she wouldn't have had the confidence to rely on her mother for support and advice.

9.3.8 Education and Social Care records (foster care recording sheets) show that whilst C74 had initially developed some close friends both in college and outside these had diminished over time. Those working with her at college stated that any friendship would have to be on C74's terms. A child progress report dated 10/04/17 describes how she '*devotes her attention onto her* [C74's friend] *which may be quite a pressure for*' her.

9.3.9 In minutes held by Children's Social Care dated the 1ST August 2016[8] it is recorded that whilst C74 had some friends they would often change and when asked as to why this was occurring she had stated that this 'prevented bickering and arguments developing'[9]. Health records document that she had stated that C74 felt that she 'had nobody there for her'.

9.3.10 Due to the fact that C74 had no close network of friends she would often spend a great deal of time in her bedroom when she was not at college. Concerns had also been raised[10] that C74 would use her foster placements to hide from interaction with others

[8] Whilst outside of the terms of reference this has been included as it highlights how C74 would keep many people at arm's length due to life experiences.
[9] Children's Social Care minutes dated 29/02/16
[10] Children's Social Care minutes 16/01/17.

and that this was not healthy. Within college it was reported (Education/Social Care) that she also preferred to spend time in student support rather than in classes.

9.3.11 From the interviews that were conducted and from agency records it would appear that C74 never felt confident enough to confide in any one professional. Carers and professionals have stated that due to the complexity of her life she had become insular and described that it was difficult to penetrate the protective shield that she had built up around her (Education/Social Care). Her social worker stated that she;

> *' is a complex young person who is very bright and can pre-empt people's reactions to her words and actions'.*

On the 22nd August 2017 a further entry that was made by her social worker in Social Care records stated that;

> ' *her emotional health and wellbeing continues to be of concern at times, she finds unfamiliar situations or people very anxiety provoking and this can present as rudeness. When in fact its C74 struggling to know how to communicate her distress'*.

9.3.12 In March 2017 C74's behaviour and emotional stability appeared to change. She had become anxious, had a poor self-image and she would self-harm. Those people that were around her were unsure how best to help her manage her anxiety and depression. On this occasion the pre-cursor to this behaviour would appear to have been the loss of contact that she had with her brothers (according to C74) as they had been adopted.

9.3.13 CAMHS records state that following C74's overdose on the 27/11/17 she was;

> *'extremely cagey about what information she would divulge… C74's presentation is consistent with her diagnosis of emotional instability. Although it is difficult to ascertain a direct trigger for this overdose it is our impression that C74 had a build-up of negative emotions that she was unable to process or endure and therefore overdosed in an attempt to stop the pain rather than kill herself*'.

9.3.14 From interviews with those members of college staff who had worked with C74 it is clear that she didn't want those people that she trusted to see her in a negative light. They believed that she feared losing the trust of the professionals that worked with her and by doing so they would not give her the support that she wanted and needed. A representative from the college described how she had not attended one of the Child in Care meetings and after reading the minutes had become extremely angry about how her behaviour (after visiting her brothers) had been portrayed by professionals. Following this staff at the college state that she was determined to attend meetings to ensure that she was portrayed more positively to those working with her.

9.3.15 When interviewed it was clear that C74 was aware of her vulnerabilities but stated that no one agency had actually met her specific needs. She felt that she wasn't believed and that any interaction was dominated by professionals who appeared to be fixated

with her mental health rather than interacting with her to find the true reasons behind her anxiety and depression. C74 didn't remember having detailed conversations with any professional about her situation. C74 stated that no-one 'asked her the right questions' and had they done so she stated that she felt that she would have told them about the underlying causes of her behaviour. C74 stated that she didn't feel comfortable in opening up to anyone.

9.3.16 Assessments and risk assessments appear to have been conducted in a timely manner and in accordance with National guidance [11] and local procedures. The focus of meetings was on the child with C74 being encouraged to contribute to the plans for her future. C74's 'voice' is evident in much of the documentation held by agencies (Social Care, Health, Education). Service provision and decision making were regularly reviewed by staff and supervisors, as was their impact on C74.

9.3.17 From agency records (CAMHS, Social Care) professionals had at each LAC review and in the risk assessment processes considered indicators of abuse or exploitation. Professionals working in Health, Social Care and Education recognised that C74's history[12] and her mental state at that time made her vulnerable but in this case there were no specific indicators that abuse was occurring. As a consequence no additional risk prevention measures or plans (specific to sexual exploitation) were put into place or considered necessary. On the information that was available to all agencies at that time this assumption would appear to have been a reasonable.

9.3.18 There were occasions when agencies unwittingly increased C74's vulnerability and feelings of mistrust of professionals and her foster carers. At the time when her foster placements broke down her belongings would be placed in plastic bags. Those that worked with her at the college described how this had a huge impact on C74 and how this undermined the trust that professionals had taken so long to build up. C74 felt that her belongings should have been treated with care and dignity and boxed up **(Recommendation 1).**

9.3.19 There were a number of occasions when professionals and carers had to search C74's room due to concerns about her hoarding medication and concealing sharp objects. This also had a similar effect on C74 in that she felt this was an intrusion on her privacy and that these actions generated feelings of mistrust. On review this action was felt to be necessary and a proportionate response to the risks identified.

9.3.20 C74's carers believed that at the time that CP4 abused C74 she was at a particularly vulnerable period in her life. Not only was she coping with the breakup of her family, and being placed with new foster carers, she was also preparing to take her exams.

9.3.21 Children and young people in care settings are known to be a particularly vulnerable group to being exploited [13] and C74 was no exception as she had a number of behavioural risk factors that made her susceptible to being victimised. These vulnerabilities are used by perpetrators to assist them in the grooming process. These

[11] Working together to Safeguard Children (2015) – Current version (2018)
[12] Evans (2019)
[13] Oakley (2018)

risks would have been clearly apparent to CP4 and he used them to assist him in grooming C74 and to manipulate her into believing that he loved her. This manipulation included persuading her to keep the abuse secret. This will be discussed further in paragraph 9.6.

9.4 Support for C74

9.4.1 From the history documented by all agencies involved in this review C74 had little support from her family. In addition to having contact with her mother Social Care looked at options for her extended family to provide that support. Following review these family members were either unwilling or unsuitable for C74 to maintain contact with due to their chaotic lifestyles.

9.4.2 From evidence presented in the chronologies that were submitted by agencies, interviews with professionals, and from the feedback from C74's foster carers it would appear that the care and support package that was put into place to promote the welfare of C74 was comprehensive. This included access to counselling at college, and Health (although there were apparent deficiencies in CAMHS clinical care package which will be discussed later in the report) intervention and regular contact with one main social worker (SW1).

9.4.3 Records from Social Care, Health and C74's foster carers show that there was a great deal of communication and information sharing between agencies prior to her placement. This initial contact ensured that they were all aware of C74's risk assessment and how vulnerable she was. The foster carers that she was finally placed with state that they felt that this level of interaction was unusual and allowed them to effectively prepare and manage the complexities of C74's character from the moment that she was placed with them. This level of interaction was praised by her carers and should be seen as best practice.

9.4.4 The importance of placement planning which is focused on risks and vulnerability is well known amongst professionals[14]. Attempts were made by Social Care to ensure that they found the right foster carers for C74. The emotional demands of dealing with C74 were however substantial for all of her foster carers and many found that they were unable to adequately cope with her overwhelming need for support. SW1 described how C74 would actively come across as though she wanted to 'be starved of affection'. Many of those carers that she had been placed with were unable to comprehend this and despite many attempts were unable to persuade her to participate in social activities.

9.4.5 The Health representative on the panel acknowledged that many young people who are in care will often create an environment in placements which makes them feel comfortable and safe. C74 would often remain isolated in her bedroom and CP4 would later take advantage of this vulnerability.

[14] Farmer (2000).

9.4.6 C74 would often state to Social Care that she didn't like her initial placements and that she wanted to move. One of her foster carers described how difficult C74 was to manage stating that they felt exhausted as often the interaction with C74 was on her terms and that the complexity of her life and forced her to become controlling. Minutes of Children's Social Care meetings and foster carer recording sheets show that respite was considered and put into place to 'eliminate the intense dynamic building within placement and with the aim of preventing placement breakdown'[15].

9.4.7 Where appropriate C74's foster carers received regular contact with her social worker and were able to communicate with them at any time if they had concerns. On review it is difficult to see what additional support could have been given to foster placements other than that which was delivered.

9.4.8 Despite the intervention that was put into place however the arrangements with C74's foster carers prior to her final placement eventually broke down for a number of reasons including an inability to manage the complexity of her behaviour and illness of the carer. Although C74 had experienced the breakdowns of placements in the past this particular one was seen by C74 as stable and supportive and therefore she was disappointed by the need to move again. In total C74 had been placed in three foster care placements.

9.4.9 In terms of C74's views on being placed in foster care she had stated whilst professionals may have felt that this was affecting her and making her 'sad' that this was not in fact the case. C74 stated that her home life was better since she had been in foster care (Crisis Resolution and Home Treatment Team assessment dated 06/03/17). She did however state that she found moving unsettling and as previously stated this was often a trigger point for a deterioration in her behaviour. The true impact of this on C74 could not be assessed as she never discussed it in detail with any professional.

9.4.10 The foster carers for C74's final placement state that they felt that the matching by social care was also extremely good. They felt that review meetings were held in a timely manner and that on the whole agencies had consistently sent representatives which they thought was excellent and unusual in their experience.

9.4.11 In response to C74's behaviour and the risk factors that were identified by professionals safety plans were drawn up in consultation with C74, her foster carers and her social worker. On reflection C74 and SW1 have stated that these plans were simplistic and were completed as a 'tick box exercise' **(Recommendation** 2)

9.4.12 Risk assessments were also regularly reviewed together with C74's carers. Her foster carers described it as 'team [C74]'. C74's foster carers state that in their nineteen years of experience it was the best support package that they had seen for a young person in Care. That support package centred around Education, CAMHS and social work intervention. C74's foster parents state that they were confident that they could 'pick

[15] LAC Minutes 16/01/2017.

up the phone at any time and would be able to contact agencies for advice and support'. This should be seen as good practice.

9.4.13 The college that C74 attended was also a central part of the care package and they had offered high levels of support and a personal education plan to meet her specific needs. Those that worked with her stated that she would often seek out a maternal figure for support and that where possible they ensured that such a person was available to her. This level of support should be seen as good practice and such intervention is known to have positive results in terms of the outcomes for looked after children[16].

9.4.14 C74 had access to weekly counselling sessions and pastoral support and described the college as 'as her family' (12/10/17). It was apparent from Education records and from the interviews that were conducted that in the main C74 felt comfortable in that environment and was well supported. When interviewed C74 confirmed this.

9.4.15 Attempts were made to constantly include C74 in mainstream education in order to reduce any feelings of isolation but there was also an acceptance that staff had to work with her in order to ensure that she remained engaged within college. On speaking to senior staff at the college it was clear that they had intervention plans in place to minimise the opportunities that she could harm herself and that their approach was constantly reviewed to ensure that it met C74's needs.

9.4.16 Those at the college have stated that as a result of the intervention that was put into place C74 relaxed her guard and that she developed trust with a number of members of staff. Ultimately this level of trust enabled her to disclose the abuse that was happening to her.

9.4.17 The college offered C74 one to one tuition and additional money was found to support this. This level of support should be seen as good practice and enabled C74 to attend college without the need for exclusion. Research[17] has shown that excluding young people like C74 simply increases their vulnerability and the ability to exploit them.

9.4.18 In minutes dated the 3rd July 2015 it is recorded that C74 liked using the college counselling service rather than accepting CAMHS input. Minutes (29/02/16) state that attendance at these sessions dropped off but C74 was aware that she could access them at any stage and she stated that she 'would make it known when she feels she needs extra support'. Reports from the college however also indicate that C74 was not confident in asking for help or speaking out those issues that were affecting her.

9.4.19 The college were also offering C74 THRiVE[18] and student support at times when she found it difficult to be at college and in lessons. C74 also had an advocate to provide help and support. Those that worked with her often went out of their way to ensure that she didn't feel let down by them. There were examples were staff who had left the college had returned to visit her. They had also sent birthday cards to C74 in order that

[16] Hallett et al (2019)
[17] Gill et al (2017)
[18] The **THRIVE** approach provides a way of working with children and young people to support optimal social and emotional development and equips those undertaking the process to re-engage with life and learning.

she didn't feel as though those who had been supporting her had stopped thinking about her. Staff stated that they wanted to demonstrate to C74 that adults could be trusted and their support was unconditional which was something that she had not experienced during her childhood. This level of support went beyond that WHICH IS normally expected and is good practice.

9.4.20 C74 was consistently supported by one particular social worker (SW1). SW1 was proactive in co-ordinating the care and support from agencies and was the lead agency worker in charge of her case.

9.4.21 Those agencies that worked with C74's social worker describe her as robust and forthright in her approach with one professional describing her as a' champion for the rights of those children that she was allocated to support'. This level of support and continuity should be seen as good practice and is known to increase the level of positive outcomes for children and young people in Care[19].

9.4.22 Out of all the professionals involved in the care of C74 SW1 provided the one single point of contact that she could call upon should she have chosen to have disclosed any issues that were affecting her life. This social worker had and continues to provide a level of support to C74 that goes beyond that which would normally be expected. The social worker has described how they have developed a professional relationship of support and mutual admiration for each other. SW1 saw herself as being particularly protective of C74 and therefore was surprised that she was unaware of the abuse that was occurring.

9.4.23 Despite the closeness of the professional relationship between SW1 and C74 CP4 was able to manipulate her into mistrusting the very person who was trying to protect her from exploitation. This demonstrates the level of coercion and control that he was able to exert on C74 (see section 9.6).

9.4.24 There was clear evidence reported in Children's Social Care minutes which shows that C74 was being included in the management of her case and that she had a voice at the various meetings that were held to co-ordinate her care. One child progress report (10/04/17), however, reported that efforts to ensure that she was included in the decision making process could be frustrated by the fact that C74 was' reluctant to formally contribute anything that reminded her that she was a young person in a care setting'[20].

9.4.25 Where C74 did participate her wishes would appear to have been recorded within the minutes of each of the meetings and this should be seen as good practice. Foster Carer recording sheets also recorded her voice in terms of her views, feelings, aspirations and her determination to better her life. Despite these efforts to include C74's voice she felt that professionals still failed to listen to her and to truly understand her feelings and needs.

[19] Care Knowledge (2019)
[20] Child Progress report (10/04/17)

9.4.26 Those that worked with C74's at college have stated that those professionals working with her recognised that she wanted to have control over her life and often it was difficult to find the balance between protecting her from further harm and providing her with the choices that she desired. Foster carer recording sheets clearly show that all of those that were working with her were trying to encourage her to become independent through taking responsibility for her own actions.

9.4.27 On review it was felt that the correct balance was found and where possible professionals worked hard to compromise and work with her. Despite some professionals stating that they found it difficult to manage C74 there has been nothing found in this review that would indicate that decisions that were made were unduly influenced or that her welfare was compromised as a result of professionals trying to meet her requests. All (except for CP4) appeared to have C74's best interests at the heart of the service that they were trying to deliver.

9.4.28 Social Care were actively working with C74 and were looking to deal not only with emerging issues but were planning for her future. At the time of the disclosure agencies were working together to support C74 to pass her GCSE's and to work towards possible further education. Plans were also being put into place to ensure that a continuity of care was in place post her eighteenth birthday.

9.4.29 C74 had substantial involvement with CAMHS during the period covered by this review. The agency had been involved with C74 over a number of years and records state that they were aware of the need to provide accessible services as they felt that C74 was difficult to engage with.

9.4.30 From the details recorded in the chronology, CAMHS initial report ,interviews and from the records that were submitted during the review it was not clear who had overall clinical responsibility for C74's case. There was a similar lack of clarity in respect of the detail of her clinical care plan.

9.4.31 C74 has since stated that the care and support that she was provided by CAMHS as a service was poor and that they failed to listen to her. She felt that they didn't appear to have the training and understanding required to deal with a young person who had presented with her needs. Throughout her time with CAMHS C74 stated that she hadn't lied to any one professional and had they asked the right questions she would have truthfully answered them. She described how they constantly applied their own values to her situation such as believing that she was self-harming as she was up upset without truly looking at the reasons why this was occurring. C74 felt that both CAMHS (and her foster carers) saw her as a burden and this prevented her from opening up to them.

9.4.32 Whilst numerous CAMHS professionals worked with C74 she had apparently come to accept and rely upon the help of two particular individuals, one of whom was CP4. CP4 had been present from the start and had been at the initial meeting with C74 and the foster carers in her last placement.

9.4.33 The support plan for C74 that was agreed included CAMHS taking her out three times a week. C74 also had access at times of need to the CAMHS Crisis Resolution and Home Treatment Team (CRHTT). The level of support and the length of time that the CRHTT were involved in this case was seen by the Panel and the independent CAMHS adviser as unusual. Normally this service would only provide short term assistance and specific interventions over a period that would not exceed six weeks. The independent CAMHS adviser felt that this was unusual practice and something that should have had regular supervisor oversight.

9.4.34 As a consequence of the agreed support plan those professionals that were supporting her, and her carers, believed that CP4 was just doing his job. Many of them thought that CP4 was delivering a service beyond that which they had experienced from other CAMHS workers. CP4's level of interaction was positively viewed at the time due to C74's level of need and lack of trust of other professionals.

9.4.35 Those individuals involved in the review have stated that they were used to the CAMHS service being overstretched and unable to meet requests for assistance in a timely manner. Professionals and carers therefore welcomed their intervention on such a regular basis.

9.4.36 Carers stated that CP4 would often turn up at their home address and would park his vehicle down the road so they were unaware of whether he was alone or accompanied by another professional. Even if he had been alone it was unlikely to have raised any suspicion due to the fact that on many occasions CAMHS workers had to work independently due to staff numbers and commitments.

9.4.37 In July 2017 C74 had apparently stated that she didn't want to change CAMHS workers (although it was later established from C74 that CP4 had influenced this decision). At the time this would not have been questioned as there was a genuine desire to deliver continuity by those delivering her care and to ensure that she had the support that she actually wanted. Agencies have in the past been criticised in other national reviews [21] and literature[22] for a failure to provide such continuity in the care of vulnerable groups.

9.4.38 In the weeks and months leading up to the disclosure CP4 was seen by other professionals and carers as having a constructive professional relationship with C74. Many other professionals had tried and failed to gain the same level of trust and therefore CP4's intervention was seen as a positive factor in addressing C74's welfare needs. This would have been a natural and justified conclusion at the time.

9.4.39 Social Care and CAMHS records document that C74 continued to be difficult to engage with throughout the period covered by this review. C74 would often state that she no longer wanted engagement with CAMHS (27.06.17, 01.08.17) and again her apparent acceptance of CP4 was seen as positive factor that enabled CAMHS to continue to work with her to address her mental health needs. As a result of the meeting with C74 it has been identified that CP4 had manipulated her into behaving and saying particular things in order for him to maintain the level of control that he had over her.

[21] NSPCC (2019)
[22] Le Grand j (2007)

9.4.40 During 2017 C74 attended Accident and Emergency (AE) Departments on five occasions as a result of self-harming injuries and her attempting to take her own life through overdoses. Those that worked with C74 describe her as being in a state of constant crisis.

9.4.41 From agency records it would appear that their response to C74's self-harm and attempts to take her own life were timely and proportionate. Agency and foster carer records show that professionals had worked with C74 to try and prevent such behaviour through discussions with her and through therapy sessions. Self-help was also provided in terms of a self-harm kit. C74's foster carers also took appropriate action on those occasions when they had discovered that she had injured herself or had taken an overdose.

9.4.42 On the 27th September 2017 C74 reached a particularly low point in her life and was voluntarily admitted to a tier 4 unit due to her anxiety and the fact that she was presenting with high levels of intent in terms of taking her own life. At that time professionals felt that they could not keep C74 safe in the community. Records clearly show the rationale behind this decision which was not taken lightly. This decision would appear to have been proportionate and necessary in the circumstances.

9.4.43 C74's experience at the CAMHS tier 4 unit was not favourable and during a drop in session at her college she spoke to Health staff of her experiences there. C74 stated that her self-harming had increased as a result of her experience at the unit.

9.4.44 The independent CAMHS adviser has stated that on reflection there was a missed opportunity at the tier 4 unit in that a comprehensive assessment could have been completed and that questions could have been raised as to why the CRHTT instead of the core team had the majority of contact in her case.

9.4.45 Whilst information about incidents of self-harm was shared to all agencies and the post management of C74's care was largely co-ordinated there was an occasion when the discharge process could have been more effectively managed.

9.4.46 Following an overdose on 27th November 2017 C74 was admitted to hospital. Two days later staff at C74's college were informed that she had been seen by CAMHS for post assessment that morning following discharge from the hospital. During this process C74 disclosed that she had access to a source of medication at the college. The college immediately acted upon this information and completed a search. CAMHS had then concluded that C74 was well enough to return to college that same afternoon. College records state that they were surprised that this decision had been made without any agency or strategy meeting to confirm risk assessments or planned operating procedures **(Recommendation 3**).

9.4.47 College records state that these concerns were brought to the attention of social care and CAMHS and following escalation reassurances were provided that appropriate safer care plans had been put into place. This escalation was completed in line with stage one of the local Escalation Policy.

9.4.48 An entry on the 29th November 2017 in the records held by C74's school stated that at the next Children's Social Care meeting (which was to be held on the 15th December 2017) a 'team around C74' would be generated as 'an active monitoring group that would come together fortnightly to review C74 going forward'. It would appear that whilst this 'team' was in fact in place there was no fortnightly review. Those spoken to as part of the review were unable to articulate why this didn't take place other than the fact that events appeared to take over this process. Where such action is decided upon then it should be followed through or the rationale recorded as to why it did not take place.

9.4.49 In order to develop her confidence and trust C74 was encouraged to have her own independence and would regularly go out on her own. This independence included access to a computer and mobile telephone. C74 had been given advice by SW1 about safe practices when using the internet and safeguards were put into place by her foster carers (such as restricting access at night times).

9.4.50 C74's carers had noticed that she was going out on her own more in the months leading up to the disclosure and they had challenged this behaviour. C74 would however state that she was meeting friends or going to the local supermarket for a coffee. On the evening before her disclosure she had stated that she was going to see a friend and after leaving her home address her carer had gone to the supermarket to check on her welfare. C74 was not there. This would appear to be the only change in behaviour that was identified that had raised some concerns.

9.4.51 C74's carers had spoken to her social worker and raised concerns about her going out but it was felt that she had to have her own independence and needed to develop social confidence. Those supporting C74 were able to maintain contact with her and she would on the majority of occasions comply with any terms that her foster parents or social worker had set. Had C74 been challenged at any stage then it is unlikely (on the information known) that she would have disclosed her interaction with CP4 due to the level of control that he had over her and the fact that she had previously demonstrated a reluctance to be open with professionals.

9.4.52 There were however occasions where professionals involved in her care acknowledge that C74 had been let down by services. These will be described below.

9.4.53 After C74 had made her disclosure her foster carers stated that they felt that the urgency to investigate and the need to secure evidence appeared to take precedence over the welfare of C74. They felt that there was no consideration of the fact that C74 was due to take her examinations at college which would have had a direct impact on the rest of her life and they believed that this 'was very destructive for her life chances'.

9.4.54 C74's foster carers also felt that a lot of pressure was placed on C74 by services and whilst they had advised professionals to take it slowly they failed to listen to what they had to say. Her foster carers also state that they felt that some of the information that they were provided with by the police regarding issues such as the seizure of C74's phone was inaccurate.

9.4.55 Foster carers should be seen as an integral part of the multi-agency approach to any crimes of this nature particularly as they have to support young people through the aftermath of the disclosure and investigation. Foster carers therefore need to be brought into the decision making process, and whilst they may not agree with the progress of an inquiry at least they will be able to understand the rationale as to why certain lines of inquiry are taking place **(Recommendation 4)**.

9.4.56 During the period post disclosure C74's foster carers state that despite her needing additional support she was provided with a CAMHS contact from outside of the area (this would be normal practice). The support provided failed to address the needs of C74 and she was left feeling completely isolated and alone. As a result C74's carers felt that the subsequent overdose was inevitable. Social Care and Health should review their current practices in order to ensure that where possible there is a continuity of care following any disclosure. Such a review should ensure that any support that is provided is regularly assessed to ensure that it meets (where possible) the needs of the victim **(Recommendation 5).**

9.4.57 C74's foster carers also lost their support worker immediately following C74's disclosure (16th March 2018) as they had apparently known CP4. At a time of crisis the foster carers felt that they were left alone and without a support network until the 23rd March 2018 when the next allocated worker was put into place. During this interim period social care records show that the foster parents received support calls from a fostering team manager which they felt was insufficient. The foster carers did however receive peer support which is discussed at paragraph 9.10. On review there is policy and practice in place to provide support and Children's Social Care have concluded that the next allocated social worker was put into place as soon as was practicable.

9.4.58 There were also periods when C74 had been admitted to hospital when she was also left isolated. During the investigation C74's mobile devices were seized. This was necessary to secure and preserve evidence (approved as a positive safeguarding measure by multi agency partners to prevent continued contact with CP4[23]) but left C74 with no means of communication. C74 has since stated that this had a devastating effect on her confidence and compounded her feelings of being alone and unsupported. She stated that her mobile and tablet were the only means of communication that she had with the outside world and that their seizure prevented her from maintaining contact with the few peers that she had developed friendships with.

9.4.59 Whilst C74 understood the need for the seizure of this equipment and the fact that there were concerns about continued contact with CP4 she described that it took an inordinate amount of time to replace the items and this impacted on her mental state. Whilst this situation is difficult for agencies to manage Children's Services should work with the young person to ensure that any impact is minimised **(Recommendation 6).**

[23] C74's initial mobile phone was never seized though attempts to gain her consent were made and this lead cp4 being involved in its destruction. A second phone and sim card had been given to C74 by CP4.

9.4.60 C74 has also recalled that her foster carers had dropped off a bag of her belongings and had stated that she would not be coming back to live with them. C74 felt very isolated as a result of the decision to move her again.

9.4.61 During this period hospital staff recognised the need for C74 to receive additional support and they contacted her college asking whether they would visit her. College staff supplied C74 with clothes, toiletries and more importantly with company and support. They arranged a rota to ensure someone was there to support her and much of this activity took place in their own time **(Recommendation 7).**

9.5 Recruitment of CP4

9.5.1 In April 2017 the CAMHS service had received funding to set up a new crisis CRHTT. This was a pilot team as long term funding had not been agreed. As a result of this uncertainty CAMHS decided that they would employ locum workers to provide the staffing that they needed. Two locums, one of which was CP4 were appointed.

9.5.2 The CAMHS Team manager at that time had used an agency to recruit the locum workers. This agency was known to be reputable and they had been used on previous occasions. The manager had asked the agency to send them a suitable curriculum vitae for the positions that were required. CP4's skills and experience were deemed appropriate for the position of deputy team lead.

9.5.3 CP4 met all the Trusts specified requirements including a current DBS to enhanced level and references. These references were checked. CP4 had also worked in a neighbouring area and some locums that were already working for the service had also worked with him previously. Again no issues were raised regarding his competency or behaviour. CP4 was also interviewed by CAMHS managers. The safer recruiting checks that were carried out would appear to have been robust and in line with National guidance[24].

9.5.4 Whilst CAMHS do not have a specific recruitment policy they follow Trust practices[25]. The Trust only uses agencies that are on the approved NHS framework.

9.5.5 The agency that CP4 was employed through confirmed that he had completed all mandatory training including safeguarding. CP4 was therefore sufficiently trained and up to date with his training.

9.5.6 Feedback from a CAMHS manager did state that they do not generally provide additional training as a result of the expectations that are placed on the agency. The CAMHS manager however did state that it was likely that CP4 could have attended 'Functional Analysis of Care Environment' risk assessment training. The agency was however unable to find any records relating to CP4. Comprehensive records should be maintained on all members of staff to ensure that they meet training and professional standards **(Recommendation 8).**

[24] Working together 2019
[25] [Local] Temporary staffing policy (H32)

9.5.7 CP4 was required to undertake NMC revalidation[26]. Revalidation is the process that allows practitioners to maintain their registration with the NMC. This process involves reflective practice, written evidence. CPD and a declaration by the person submitting it regarding their character. This includes a consideration of any:

- criminal proceedings
- findings by another regulatory body (including health and social care)
- conduct which may amount to a breach of the requirements of the Code.

9.5.8 The local Foundation Trusts 'Temporary Staffing Policy' states that it is the responsibility of the Department to ensure that any temporary staff receive a local induction. CAMHS have confirmed that CP4 had no induction training 'as this would have merely repeated his mandatory training'. The CAMHS manager stated that he would have a general induction in terms of familiarisation with the building in which he was housed and how to use their electronic recording system. They stated that they would not expect to do much more for someone with such extensive CAMHS experience'.

9.5.9 As a registered nurse CP4 was expected to abide by his professional code of conduct and therefore didn't sign any additional documents about local standards and expectations. Best practice would however be to ensure that as part of the induction process any locum is reminded of the Trusts standards and expectations **(Recommendation 9).**

9.5.10 Since disclosure the internal practices within CAMHS have changed (December 2017) and in order to provide additional independence to the process all locum staffing requests now go through a specific temporary staffing team.

9.5.11 There has been nothing found as part of this review that would indicate that CP4 had entered his profession in order to gain access to children and young people in order to sexually abuse them.

9.6 <u>Abuse of Trust by CP4</u>

9.6.1 In this case CP4 seriously abused his position of trust. People who abuse children in organisational positions of trust are defined as;

> *'anyone working with children who have sexually offended against a child or young person in a context directly paid to their paid work or volunteering activity' (Beyer et al;2005).*

[26] How to revalidate with the NMC.NMC (2019)

9.6.2 The standards of behaviour and professional practice expected from those working within Health including CAMHS are clearly laid out by the Nursing and Midwifery Council (NMC)[27].

9.6.3 CP4 would appear to have targeted C74 due to her vulnerability. Her age, emotional and psychological state (lack of self-confidence and low self-esteem) made her vulnerable and it would appear that CP4 manipulated that vulnerability as a means of sexually exploiting her.

9.6.4 C74 stated that CP4 knew what had happened to her in the past and that he had used this to establish gain her trust and abuse her. She stated that 'he did to me what others had done in the past'.

9.6.5 CP4 was in a position that enabled him to develop an exploitive relationship and used his authority to facilitate the abuse. C74 described how she felt that his behaviour to her was inappropriate from the start and that this had become apparent to her from the moment that he had met her.

9.6.6 C74 stated that she has since learnt about grooming and that she had developed a view that in such situations victims do 'things' with consent and because they want to. She stated that she felt that she wasn't a victim in this sense as she was made to do things against her free will by CP4. C74 stated;

> "certain things happened to me when I was younger. That type of behaviour disgusts me but he went on to do the same things…"

9.6.7 CP4 had groomed and put C74 under so much pressure that she had no choice but to give in to his demands as 'he knew that I [C74] didn't have people around me that I could trust'. She stated that the things that he did to her would upset her but that he would then comfort her and make it feel that it was her fault. These are known grooming techniques.

9.6.8 The panel and the author believe that CP4 used recognised grooming techniques[28] to gain the trust of C74 prior to facilitating the abuse. He had preyed on C74 at a time when she was socially isolated and starved of affection. C74 described how he appeared to be the only one that understood her.

9.6.9 CP4 had convinced C74 that she had no mental health concerns and this was contrary to what others including other CAMHS professionals were telling her. CP4 wouldn't discuss these issues with her and instead he would give her compliments and talk about other issues affecting her life. CP4 made C74 feel wanted by calling her 'special' and he filled a void in her life in respect of support and affection.

9.6.10 CP4 had lied about his family and married life to C74, allowing her to believe that she was in a consenting relationship with a person who could provide her with the love and care that she had craved for throughout her life.

[27] The Code & Standards for Competence for Registered Nurses (2010); NMC.
[28] Pollack et al (2015)

9.6.11 In order to commit a sexual offence and get away with it perpetrators will prepare or 'groom' the victim and others who might protect the victim (Sullivan; 2002). CP4 had convinced C74 that she could not trust other people by constantly reinforcing negative views about them. From what was said post disclosure it would appear that he would use the conversations that he had with professionals to undermine C74's confidence and trust in them. These are classic grooming techniques used by perpetrators of abuse. These techniques ensure that their victims do not trust those around them and minimises the chances that they will disclose the abuse to others. As stated in paragraph 9.3 C74 was already isolated, difficult to engage with and she had a natural distrust of others.

9.6.12 CP4 had initially gained access to C74 through legitimate contact either at her home address, in college or through health appointments. CAMHS were considered to be the most competent agency to deal with the issues that C74 was facing.

9.6.13 C74 has stated that she didn't question the number of visits by CP4 initially as she believed that CAMHS had authorised them. Professionals working with him and C74s carers believed that CP4 was delivering a great service and therefore had no reason to question his motives or the frequency or his visits.

9.6.14 CAMHS have verified that CP4 didn't specifically hold C74's case and that depending upon the nature of the commitment anyone of the workers could be allocated to deal with her. This is verified within their records and the chronology which show that other CAMHS practitioners also attended her college and home address on numerous occasions.

9.6.15 Where possible and because C74 had built up a rapport with him CP4 would be used on the more routine appointments. In cases involving vulnerable young people with a mistrust of professionals this would be considered to be good practice as the allocation and use of single points of contact improves consistency and stability for those deemed to be vulnerable.

9.6.16 The review has been unable to verify exactly how many times CP4 went to C74's college where he would speak to her in private. These meetings would take place in a meeting room located between two other offices where other professionals were working. This area was therefore considered to be a safe place. The college also confirmed that Individuals seeing support workers are always given the option of having a member of college staff present during these meetings. Whilst C74 chose not to take up this option in this case this should be seen as good practice.

9.6.17 Those working at the college believed that CP4's visits were part of the agreed plan to support C74. There would therefore have been no reason to have questioned CP4 about the purpose of his visits or have any belief that something untoward was occurring. On many occasions these visits were spontaneous with little or no notice being given to the college. On occasions CP4 would also ask the college to tell C74 that he couldn't make meetings and that he would see her later that evening. Had the

multi-agency safeguarding meetings been effective then the extent of contact may have been identified as being unusual and concerning.

9.6.18 C74's college has since changed their policy and will only facilitate meetings that have been prearranged by agencies.

9.6.19 Panel members felt that whilst college staff had no specific reason to question the visits there could be learning from this case that could protect other vulnerable individuals in all colleges. In order to tighten up processes and to increase accountability and transparency it was felt that all meetings with professionals in colleges should only take place if prearranged. On these occasions the purpose of their visits should be clearly stated from the outset. All such visits should also be highlighted to the safeguarding leads within those establishments. These arrangements would provide some oversight, ensure that the safeguarding leads are integral to any work taking place with the individual, and prevent disruption to the young persons' education **(Recommendation 10).**

9.6.20 CP4 had arranged to meet Child A outside of his normal work environment and this has been found to be a common method used by other offenders who had professional positions (Sullivan and Beech 2004). The exact number of times that he actually met her has not been ascertained however C74 has stated that he would generally see her on a daily basis. The Police also identified that he had made over one thousand calls to her phone and had sent a text roughly every thirty seconds to a minute (not accounting for sleep). CP4 had provided C74 with a mobile phone to facilitate contact and to prevent others from finding out about the abuse.

9.6.21 From the disclosure made by C74 to Police and from talking to her it is believed that the abuse started just before Christmas and her sixteenth birthday. From the information that is known it would appear that the first sexual intercourse took place when CP4 met her on the 20th December 2017.

9.6.22 Initially there was a period when CP4 groomed C74 through flirting with her. During this period there was no touching or sexual contact between the two. CP4 through grooming techniques continued to gain her confidence and developed their friendship until he eventually persuaded her to have sexual intercourse with him. C74 stated that there was no physical attraction between the two of them just an emotional connection.

9.6.23 C74 has stated that she had initially resisted CP4's advances but he would pressurise her and then stop being nice to her (part of the grooming process) when she declined to have sex. As he was the only person in her life that treated 'as a human being' she ultimately felt as though she had no choice but to acquiesce to his requests. C74 stated that it was almost like self-harm in that 'even though things were horrible you just get used to it. It would make the connection even stronger'.

9.6.24 It is unclear from the information that is available to agencies what CP4's intentions were in the longer term. In February 2018 C74 told her social worker that CP4 had stated that she was going to be discharged from CAMHS. This was then immediately followed up by C74's social worker but CP4 denied that he had said this. C74 later

informed the police that she and CP4 had discussed this as he had stated that she would need to be discharged in order for them to carry on their 'relationship'. It would therefore appear that he was looking for opportunities to continue the abuse over a longer term whilst also minimising the chances of being discovered.

9.6.25 From the discussion with C74 it was clear that CP4 was actively trying to manipulate not only her but also his peers. CP4 would brief C74 after every engagement and instruct her to tell a specific story to her foster carers and other professionals. C74 stated that he would then go back and update CAMHS in such a way as to facilitate continued access to her. C74 stated that all agencies were being led by CAMHS who in turn were being manipulated by CP4. She stated that Children's Services were heavily reliant upon the information that was fed to them by CAMHS.

9.6.26 C74 has stated that she was often made out to be a villainous and manipulative person by agencies and this had been set up through CP4 who didn't want anyone to take what she was saying seriously. Again this is a specific trait evident in grooming and enabled him to control those around him.

9.6.27 C74 had reflected that most professionals had believed that she should only be seen by CP4 and one other male co-worker as she had developed a good professional relationship with them. It had also been stated that if these workers were to be withdrawn then she would attempt to take her own life. C74 stated that this was in fact not the truth. She stated that CP4 had told other staff members in CAMHS that she had said this as he knew that he would then be allowed to maintain contact with her. She also stated that he had manipulated the situation where his male colleague was the other main point of contact as this would deflect any suspicion about male workers working with her. He also felt that he could control this male colleague.

9.6.28 During the period of the abuse there were no specific events that would have triggered suspicion by any agency specifically in relation to CP4. As stated previously C74's carers had become suspicious when she left their house but again they would have had no reason to believe that she was seeing CP4.

9.6.29 C74 did not disclose the abuse earlier as she did not recognise that she was a victim. CP4 had normalised the sexual abuse through grooming[29] C74 in such a way that she would not have recognised the coercion and control that he had over her. This level of control was demonstrated in the methods that he used. CP4's deceived C74 into doing what he wanted and this was clearly demonstrated when she became pregnant. This will be explored further in the next section 9.7.

9.6.30 CP4 was calculating, manipulative and devious and this can be seen following his arrest. In that time he attempted to eradicate evidence and had been searching the internet about how to remove incriminating files on an I-phone and a laptop. CP4 also contacted C74 on numerous occasions trying to manipulate her into withdrawing her statement to the police. During this time CP4 continued to groom C74 and encourage

[29] Erooga W (2012)

her to meet him. The two of them met on a number of occasions and the abuse continued.

9.6.31 C74 only disclosed the abuse after talking to his wife on the 15th March 2018. C74 stated that up until that point she didn't feel comfortable that she could tell people and that she didn't have a good enough relationship with any one individual that would have given her the confidence to come forward.

9.6.32 There is no evidence to suggest that CP4 had abused others in his care. As part of their investigation police had interviewed other young females who he had contact with. During these inquiries nothing was disclosed that would have raised any specific concerns or which would have had any impact on CP4's employment with CAMHS.

9.6.33 The level of confusion that CP4 was able to instil in C74 is still evident. C74 stated that when all others were failing to believe in her he offered that support and that she would return to him despite knowing he was on a number of occasions exploiting and abusing her. When spoken to C74 stated 'who would I have turned to?' She stated that she had been really struggling with her life circumstances and yet she couldn't turn to CAMHS as they were being controlled by CP4.

9.7 <u>Pregnancy</u>

9.7.1 On the 14th February 2018 C74 walked into a sexual health walk in clinic after being dropped off by CP4. On that occasion C74 disclosed that she thought she was pregnant. Until that moment none of the professionals working with her (other than CP4) or her carers were aware of this. This appointment led to her subsequently having a termination.

9.7.2 From speaking to C74 it was apparent that CP4 continued to maintain control over her throughout this period in her life and that he used it to continue to play on her vulnerabilities. C74 described how confused she was at this time and how CP4 would compound this situation by sometimes stating to her that she should have kept the child and then on other occasions telling her that the termination was the right thing to do. It was apparent that he was concerned that if the child was born then from the ethnicity of the child it would have been obvious as to who the father was.

9.7.3 Those working in the clinic that C74 attended were able to persuade her to give consent to inform her health visitor and social worker. This should be seen as good practice as it enabled those that were supporting C74 to provide the level of care that she required following the appointment.

9.7.4 C74's Social Worker informed her foster carers (without her consent) of the fact that she was pregnant and was seeking a termination. This disclosure was also made in order to provide the necessary care and support that C74 required.

9.7.5 In the weeks leading up to her pregnancy C74's foster parents stated that they felt that she was starting to become sexually active. They had conveyed this to her social worker but were told that C74 didn't need anything else in respect of sexual awareness.

Despite this they were still surprised when she had become pregnant as she had shown no interest in males at that time.

9.7.6 Following C74's disclosure that she was pregnant her foster carers were told by social care not to discuss the pregnancy with C74. This was seen by her carers as a perverse decision in that they felt that they could not fully support her at a time of extreme need.

9.7.7 The review identified that following her termination C74 had specifically requested that nobody else should be told about what had happened to her. Her social worker sought advice about this as they felt that she needed additional support in her home environment and was concerned about her welfare. C74's social worker was told by the Social Care legal team that she had to respect this request but on reviewing the circumstances with her manager they made the decision to tell her carers as she could need additional help and/or medical intervention. This should be seen as good practice as it was made in C74's best interests.

9.7.8 On the 16th February 2018 C74 had disclosed to those that she trusted at her college that she was pregnant. C74 had stated '*I have something to tell you. I think you will hate me*'. A member of staff who had gained her trust reassured her and after some time she admitted the pregnancy. C74 was described as very upset and heart broken. Those at the college who had worked with C74 were surprised about this disclosure as they state that she had no interest in boys within her own peer group and had a general distrust of males. They described her as having an almost childlike view of boys.

9.7.9 Those at the college state that C74's decision to terminate the pregnancy was driven by her overwhelming desire not to bring a child into the world due to her own childhood experiences and her inability at that time to provide the stability needed.

9.7.10 Following the disclosure of her pregnancy C74 attended the SARC for an STI screen. Records show that the social worker who was present at that time was sceptical about the story that C74 had given about who the father was. C74 was repeatedly asked if she was telling the truth but maintained her story. There were however no disclosures made about CP4 or any other specific details that could have been explored further.

9.7.11 In this case it has been confirmed by Children's Social Care that a strategy meeting should have been held in respect of C74 at the point that the pregnancy was identified. There is no rationale contained in records held by Social Care that would indicate why this hadn't happened. The review panel and those liaised with as part of the review within Social Care have agreed that such a process should be routinely followed in all cases where a child in Care becomes pregnant, due to their vulnerability to sexual exploitation (**Recommendation 11).**

9.8 <u>Supervision</u>

9.8.1 From the interviews that were undertaken the supervisors in this case had the required level of knowledge and understanding of safeguarding children. This included awareness of such issues as the identification of concerns, vulnerability factors,

remedial action required, and statutory responsibilities. They also understood their responsibilities in relation to offering advice and guidance to members of staff and the need to support them to meet their legal obligations towards children and young people. Despite this level of knowledge there were failings identified in this case.

9.8.2 CAMHS do not have a specific supervision policy but follow the Trust policies for the area concerned. The Trust where CP4 was working has a written standard that in addition to clinical and managerial supervision meetings taking place state that all staff should attend safeguarding supervision on a twelve weekly basis.

9.8.3 A manager within CAMHS has stated that this level of supervision is difficult for the CRHTT team to adhere to as the sessions do not always fall at times that are convenient for them to attend. The manager stated that this was due to shift patterns and the nature of the work that they undertake which often creates unexpected and time critical demands on their time.

9.8.4 The CAMHS managerial feedback that was received as part of this review stated that once trained specialist staff get very little guidance on supervision and that the NHS struggles to ensure that effective supervision is delivered. A CAMHS manager stated that they rely upon NMC guidance on nursing supervision. The revalidation requirements[30] are overly relied upon to overcome some of the issues of being able to deliver effective supervision.

9.8.5 National standards[31] state that the following measures should be in place;

- Training supervisors and managers in supervision, service change and development.
- The agency has clear policies on the different functions of line and clinical supervision and staff have regular access to both.
- Clinical supervision must be available to practitioners at least one hour per month
- Management supervision is available to all staff
- Supervision is delivered by staff with the appropriate clinical skills and training

9.8.6 The supervision records that were submitted by CAMHS in respect of CP4 were poor in that they lacked any detail. Records relating to the supervision of CP4 show that between the period of November 2017 and 14th February 2018 there were only twelve supervision entries on CP4's personal record. There were no entries in relation to the quality of his management of the case or entries in relation to regular workload reviews. This would indicate that poor management practices were in place during the period of this review in respect of clinical, managerial and safeguarding supervision.

9.8.7 The supervisor that was in charge of CP4 at the time has stated that although not recorded the following supervision was in place at the time that C74 was being supported;

[30] Introduced in response to National reports including the Francis report 2013.
[31] NHS England (2014)

- Handover sessions (twice daily)
- Weekly multi-disciplinary team meetings
- Management supervision (every twelve weeks)
- Peer supervision (weekly)
- Safeguarding supervision (every six weeks)

On the information provided to the review it would appear that the majority of these events (if they did occur) were not documented and the level of input in relation to CP4 could not be ascertained. From the information provided to the review there was also no clinical supervision taking place. Despite the challenges presented by the work carried out by the CRHTT it is inexcusable that effective supervision and recording practices were not in place.

9.8.8 CP4 had been moved from the CRHTT to the tier 3 service on the 26th February 2018. This was due to concerns about his productivity, his attendance and his ability to correctly follow operational practice. This move had taken place in order for managers within CAMHS to effectively manage him on a day to day basis and to identify whether the grounds that had been identified by his previous supervisor where founded.

9.8.9 CP4's previous supervisor has stated that he was difficult to manage and would often become argumentative if his practices were questioned. She did however reiterate that there was nothing to suggest that he presented a risk to others and that she felt that he was 'lazy'. This supervisor felt that their ability to effectively manage CP4 on a daily basis was restricted by the fact that he was considered to be on the same grade as they were and therefore could be considered an equal. The independent CAMHS adviser has stated that there are many occasions where this scenario could occur due to the pay bands in the NHS and the employment of agency staff.

9.8.10 CP4's previous supervisor also stated that when they raised concerns about CP4 they felt largely unsupported by their managers and therefore disempowered to challenge his behaviour.

9.8.11 In this case effective supervision within CAMHS was compromised. The senior CAMHS manager that was spoken to as part of this review has stated that the agency had recognised that supervision was poor at the time and that measures have since been put into place to ensure that all staff including locums receive effective line management supervision on a monthly basis **(Recommendation 12).**

9.8.12 From the discussions that took place with C74 it was apparent that CP4 was concerned that those working in CAMHS would find out about the abuse. CP4 was also concerned about the scrutiny from his previous supervisor. Not only did he groom C74 but it would appear that he also went to great lengths to manipulate those that supervised him including his senior managers. This manipulation ensured that there were divisions in the management structure which he exploited.

9.8.13 CAMHS must ensure that there is a culture of supportive supervision within the service and that there is an ability for any member of staff to raise legitimate concerns about other members of staff who they may work with. A failure to promote such an environment will undoubtedly lead to poor practice and failings.

9.8.14 There was also information that important personnel documentation in relation to CP4 had gone missing from the files that were kept locally or was not readily available, such as his references which had previously been held within his file[32]. Whilst this piece of information could not be verified the CAMHS senior management team must satisfy itself that processes are in place to maintain and store records in relation to staff members **(Recommendation 13).**

9.8.15 In terms of operational practice individual CAMHS practitioners largely work independently and there was no evidence presented during the review that would indicate that they are supervised whilst working directly with clients.

9.8.16 The usual working practices for CAMHS is that two workers would be present for an assessment of an individual but on other occasions clients would be seen by individual workers. This practice is due to staffing levels, daily demands and the nature of the work that they undertake. Often workers have to visit individuals at times of crisis and therefore their working practices would always be to respond within the shift period when there may be only one member of staff available. This means that without effective oversight and managerial supervision individuals within the agency are largely autonomous and are relied upon to work within professional boundaries.

9.8.17 Between the period of the 1st March 2017 and the 30th April 2018 CAMHS practitioner saw C74 thirty two times. In that same period other clinicians collectively saw her fifty nine times. The nature and frequency of contact should have been regularly reviewed and the rationale for it continuing fully documented. This did not take place.

9.8.18 Whilst effective safeguarding/managerial supervision would have been unlikely to have prevented the abuse its application would have reinforced standards and the professional boundaries that are expected within CAMHS.

9.8.19 Effective supervision is essential in identifying irregular practice particularly when individual professionals are seeing vulnerable young people on a one to one basis. Such supervision should be intrusive and constantly monitor boundaries.

9.8.20 On reflection the panel felt that all statutory agencies should audit their policies and review practice to ensure that supervision arrangements are robust **(Recommendation 14)**.

9.9 <u>Management of CP4 following arrest</u>

[32] CAMHS and CP4's agency have confirmed that references were in place.

9.9.1 Following the disclosure made by C74 those within her college took immediate action and reported the matter in line with South West Child Protection Procedures.

9.9.2 CAMHS immediately terminated their employment contract with CP4. The Nursing and Midwifery Council (NMC) were also informed so that they could take the appropriate action as per their codes of practice.

9.9.3 CP4 was appropriately referred to the LADO and C74s' carers were instructed on what to do if CP4 attended their address.

9.9.4 Following the initial police investigation CP4 was released on bail as a result of there being insufficient evidence at that time to charge him. On review the action taken by the police was proportionate and the decisions made in line with investigative and prosecution practice and guidelines.

9.9.5 In CP4's case additional evidence was required in order to support the prosecution's case and a forensic examination was requited of his computers and mobile telephone. Additional work was also required in relation to telephone data. Due to the complexities of these processes they can take time to complete and therefore in this case a decision was made to release CP4 on bail.

9.9.6 The risk too C74 was recognised and bail conditions were placed on CP4 to minimise any future contact or harm. There was active management of the case in this interim period and other investigative techniques were deployed to assist in the offender management process.

9.9.7 During the review SW1 highlighted that the bail address for CP4 was about seven minutes' walk from C74's address. This was a poor decision and facilitated access to C74 after his initial arrest **(Recommendation 15**).

9.9.8 During this period in the investigation CP4 however continued to see C74 and exert control over her. He would emotionally blackmail her stating that if he went to prison he would take his own life and had approached her to destroy her mobile phone. C74 recalled how he had taken her to a local wooded area and had demanded that she hand over her phone. CP4 had then destroyed it by stamping on the handset and he then buried it.

9.9.9 Following additional investigative work the police identified that contact was continuing (in total CP4 had purchased three mobile phones to covertly maintain contact with C74) and CP4 was rearrested. On this occasion due to the nature of evidence that they had the police were able to charge CP4 and remand him in custody. Again the action taken by the police was proportionate and the decisions made in line with investigative and prosecution practice and guidelines.

9.9.10 As part of the investigative process the computer used by CP4 at CAMHS was seized by the police. Police state that their efforts to effectively carry out the investigation were frustrated in that CAMHS would not allow access to the device. Essential evidence could have been found on the device and the failure to allow access could have

presented difficulties at trial in relation to disclosure. The police are experienced at dealing with physical and electronic material that may contain sensitive information and they will work with agencies like CAMHS to respect confidentiality. A failure to allow such access could in the future jeopardise investigations and prosecutions. CAMHS should review current policy and practice to ensure there is clear advice and guidance available to managers should such equipment be seized in the future **(Recommendation 16)**.

9.10 Treatment of Foster Carers

9.10.1 The foster carers who were looking after C74 at the time the disclosure were professionals working in the field of safeguarding and social care. Her carers state that they felt trained and were knowledgeable in relation to the issues associated with exploitation.

9.10.2 The Local Authority in the area where C74 was looked after have confirmed that training is available to foster carers in relation to child sexual exploitation and child protection. This was confirmed through scrutiny of training records. This training is not available for independent fostering agency placements **(Recommendation 17).**

9.10.3 All of the training this is delivered to foster carers should be reviewed to ensure that it includes awareness in relation to professional boundaries and abuse. **(Recommendation 18).**

9.10.4 During this period the foster carers used the Independent Counselling Service' which had been promoted in peer support groups and through the fostering magazines that they were subscribed to. This service was seen as being very supportive in providing advice and guidance. The availability of this service should be widely promoted to foster carers in area where this incident took place **(Recommendation 19).**

9.11 Professional Knowledge, Training, Policy and Practice

9.11.1 A further area for analysis was whether there was good knowledge of policy and practice amongst the professionals within the agencies involved in this review and whether these were applied in the operational setting. This includes whether appropriate services were available to those involved.

9.11.2 From the detail recorded in the chronologies and from the feedback from the managers and practitioners it has been identified that the services that were in place to support C74 were appropriate and responsive to her needs.

9.11.3 In terms of improving practice C74 stated that the language that professionals used during their contact with her had a profound effect on how she viewed them and that this often reinforced her view that they didn't believe her. One example of this was when individuals would state that C74 had 'alleged' something. C74 felt that by using this term professionals had already made up their minds that she was failing to tell the truth. Professionals across all agencies should therefore reflect on the language that they use when dealing with young people. This observation has not resulted in a

specific recommendation as this should be a consideration for all professionals working with children and young people.

9.11.4 There would appear to be good understanding of the relevant safeguarding policies and practices amongst the professionals involved in this case.

9.11.5 From the limited information available to the review all of the staff who were involved with C74 would appear to have been trained to the standards expected.

9.11.6 When interviewed as part of the review C74's foster carers stated that whilst at the hospital following the initial disclosure she was taken to a room and questioned alone for forty five minutes by a police female officer. Her foster carers felt that this as inappropriate in view of her mental health. The police have since reviewed this and have stated that C74 was seen on two occasions (17th March 2018 and the 18th March 2018) On both occasions C74 wanted to discuss her situation and she was offered the opportunity to have another person present but declined. Police also confirmed with Health staff that she was competent[33] to talk to the officer concerned.

9.11.7 C74 stated that she felt that the approach by the Police in the early stages of the investigation was insensitive and she described them as forceful. C74 stated that whilst in hospital she was taken to a room and at the same time her phone and tablet were being seized without her full knowledge. C74 felt that this approach was 'sneaky'. She stated that this was a deliberate attempt to distract her and that this had engendered mistrust.

9.11.8 SW1 stated that on this occasion they were asked by the police to assist with the seizure of C74's mobile phone and tablet in order to enable them to review their content and progress the investigation. SW1 was asked to take C74 into another room and chat with her until the police advised them that they had left the ward. SW1 then had to explain to C74 about the seizure**.** On this issue SW1 felt pressured into telling lies in order to carry out this request. SW1 stated that the police asked her to do this in order to maintain their relationship with C74. On reflection SW1 stated that they were asked to compromise their own position and would never do this again.

9.11.9 Police have stated that previous attempts to obtain the phones through gaining consent from C74 had failed and therefore they had to look at other options. The phone had been provided by CP4 and was direct evidence in relation the offence of perverting the course of justice. Police practice has since changed and consent is now required unless such items have been used in the commission of an offence[34].

9.11.10 C74 also stated that she felt pressurised into going to Court and that she was of the belief that if she failed to do so she would be subjected to being summonsed or arrested **(Recommendation 20)**.

[33] Fraser competency (Gillick Principle) originated in the House of Lords in 1985 and concerns the rights of children under 16. The courts agreed that once a child has a sufficient level of under- standing and intelligence, they are deemed capable of making up their own minds on matters requiring a decision.

[34] Digital device extraction(2019); [Local Police]

9.11.11 C74 stated that the decision to move her out of the area by Children's Services had dramatic consequences on her confidence and her mental state. C74 stated that she would have liked the opportunity to have said goodbye to her friends. It would appear that her voice had been lost at this stage in the investigative process and that decisions where being made without someone fully explaining the rationale to her **(Recommendation 21).**

9.0 Conclusions

10.1 Due to her family background and mental health C74 was an incredibly vulnerable individual who needed constant support and professional intervention. Agency records show that professionals were clearly aware of her vulnerability and the risks associated with her behaviour.

10.2 C74 was a difficult individual for professionals to manage in terms of meeting her needs. She was seen as incredibly bright and as a result professionals were aware that she would try and manipulate them so that any engagement was only on her terms. This was clearly a defensive mechanism driven by the complexity of her life circumstances.

10.3 The package of support that was put into place to protect C74 was comprehensive and there was excellent engagement by her college and social worker with her. C74's foster carers also felt that the support provided by agencies was excellent. The level of care and support that was put into place was seen by those involved to be unprecedented and demonstrated excellent multi agency interaction and working.

10.4 During the time covered by this review CAMHS played a pivotal role in providing the support and contact that C74 required. A plan to support her needs was implemented and followed with numerous CAMHS workers having contact with C74.

10.5 In relation to CP4 CAMHS followed safer recruitment practices and there is nothing recorded or identified from the police investigation to suggest that he deliberately targeted that organisation to gain access to children and young people.

10.6 CP4 was a manipulative individual who used his position as a professional to groom and sexually exploit C74. CP4 gained C74's trust over a relatively short period of time during which he was able to gain her confidence and exploit her during a period in her life when she was extremely vulnerable.

10.7 CP4 breached all ethical standards, codes of conduct and the boundaries expected of a professional. Not only did he groom C74 but he also manipulated those that he worked with in order to facilitate opportunities to engage with her.

10.8 C74 did not at the time see that she was being abused and due to the coercion and control that CP4 exerted upon her did not disclose any details to those involved in supporting her.

10.9 Although there were issues regarding the effective supervision of CP4 within CAMHS there is nothing to suggest that there were any specific warning signs that he was abusing C74. Had robust supervision been in place then this would have restricted his opportunity to exploit C74 but it is unlikely to have prevented it. There is however a need to review and audit current supervision arrangements within CAMHS.

10.10 Professionals working in the local area would appear to have the necessary training in safeguarding and there was a good understanding of policies and procedures.

10.11 The review has identified changes that are required in policy and practice for Children's Services, CAMHS and Education. These changes have been recommended in order to increase transparency and accountability and improve services to carers and those that can be considered to be vulnerable.

10.12 This is a tragic case were one individual has exploited a young vulnerable person in order to satisfy their sexual needs. There has been nothing found during this review to indicate that any one person failed in their duty to recognise and appropriately respond to the abuse that was being suffered by C74. All professionals and carers were unaware that the abuse was taking place**.**

11 Recommendations

11.2 This section of the report sets out the recommendations that have come from the learning in this case.

Learning: In this case C74 felt that the current practice used by Children's Services in relation to the collection and transportation of personal belongings was disrespectful and consequently harmed trust and confidence.

Recommendation 1.

Children Services should review current practice regarding the collection and transportation of personal belongings of young person who was in Care.

Learning: Current safety plans for children and young people in Care are too simplistic and lack sufficient detail on which to base professional decisions.

Recommendation 2.

CAMHS and Children's Services to review the effectiveness of the keep safe plans currently in place for children and young people in Care.

Learning: CAMHS failed to follow processes in this case in relation to multi agency planning and strategy meetings leaving the C74's at risk on her return to college.

Recommendation 3.

CAMHS to review current discharge practices to ensure that all relevant agencies are notified in the planning process and that risk management strategies/plans include their input.

Learning: The foster carers in this case felt disempowered by the investigation processes despite their ability to effectively contribute to the safeguarding of C74.

Recommendation 4.

Children's services to review their current policy and practice to ensure that foster carers are included in the decision making process following disclosure by a children and young person in Care.

Learning: When C74 was at her most vulnerable there was insufficient provision of mental health support to assist her through the investigative process.

Recommendation 5.

Social Care and Health should review their current practices in order to ensure that there is a continuity of care for all children and young people following any disclosure of professional abuse.

Learning: The failure to replace C74's IT following its removal/seizure was insensitive and left her isolated and increased her risk of harm.

Recommendation 6.

Children's Services to review current policy and practice in relation to the seizure/removal of IT from children and young people who are in Care.

Learning: Following admission to hospital C74 was not provided with basic provisions and left without adequate support**.**

Recommendation 7.

Children Services to review current practice to ensure that children and young people in Care receive adequate support in terms of their welfare when they are admitted to hospital.

Learning: Comprehensive training records must be maintained to ensure that safer recruitment practices are followed and to effectively monitor continuous professional development.

Recommendation 8.

CAMHS service to ensure that accurate and comprehensive training records are maintained in relation to all members of staff including locums.

Learning: As part of safer recruitment practices CAMHS should reinforce expected values and professional boundaries**.**

Recommendation 9.

CAMHS service to review current practice to ensure that all staff receive an appropriate induction to CAMHS and to include expectations in terms of safeguarding and professional boundaries.

Learning: Educational establishments need to ensure that processes are in place to monitor professional appointments.

Recommendation 10.

The Local Partnership to ensure that all education establishments adopt a practice whereby professional visits to schools and colleges are only made through prior appointments. All such visits should also be notified to the relevant DSL's.

Learning: All Children and young people who are in Care who may become pregnant should be subject of a strategy meeting.

Recommendation 11.

Children's Services to review current policy and practice to ensure that in all cases where a child or a young person becomes pregnant they are subject of a strategy meeting.

Learning: CAMHS had insufficient supervision structures in place at the time when CP4 was employed.

Recommendation 12.

CAMHS to review its current supervision structures and practices to ensure that there is effective and transparent oversight and management of all staff.

Learning: CAMHS needs to ensure that it is satisfied with the current storage and integrity arrangements in respect of its personal files.

Recommendation 13.

CAMHS to conduct an internal audit of staff records to ensure that all relevant paperwork is securely stored in accordance with Trust policies.

Learning: There is a need to quality assure current supervision practice.

Recommendation 14.

All agencies to review current policy and practice to ensure that robust supervision practices are in place to regularly review the practice of those professionals that are required to work continuously with vulnerable people.

Learning: Police should ensure that the bail addresses used by perpetrators of abuse are not located close to their victims.

Recommendation 15.

Police to review the bail process in this case to identify appropriate learning.

Learning: The current arrangements for allowing Police to access CAMHS IT is inadequate and frustrates the investigative process.

Recommendation 16.
CAMHS to review current policy and practice in relation to allowing access to agency IT seized by police during investigations.

Learning: In order for carers to be able to identify whether abuse or exploitation is occurring they need to be adequately trained.

Recommendation 17.

Children's Services to ensure that those independent foster carers that they use have received training in respect of child exploitation.

Recommendation 18.

Children's Services to review current training for foster carers to ensure that it highlights professional boundaries and abuse.

Learning: There is a lack of awareness in respect of the availability of the Independent Counselling Service amongst foster carers.

Recommendation 19.

Children's Services to promote the Independent Counselling Service to all foster carers.

Learning: Children and young people in Care need to be fully briefed regarding the investigative and court process in order for them (and their guardian) to make informed decisions**.**

Recommendation 20.

Police to review the management of C74 to identify learning regarding the management of children or young person in Care and the court process.

Learning: The movement of a child or young person in Care out of area needs to be carefully planned and implemented in order to maintain the confidence of the child concerned and to reduce risks in terms of their welfare**.**

Recommendation 21.

Children Services to review the current process of moving children and young people out of area to ensure that they capture and recognise the 'voice of the child.'

Appendix A - Author of the Overview Report

The author of the review is a safeguarding consultant specialising in writing safeguarding reviews. He also currently delivers training in all aspects of safeguarding.

The author of the review was I was a serving police officer and had thirty-one years' experience. During that time he was the previous Head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to child safeguarding. He has also previously been the senior investigating officer for complex child abuse investigations and homicides.

The author of the review left the police service in February 2017 but had spent the previous seventeen months working regionally and nationally. During that time he had no involvement with the area concerned or the policy and practices of the local police service. He also had no operational oversight of the resources that were deployed in this case.

Appendix B Chronology	
Date	**Occurrence**
03.03.17	Placement move due to breakdown of foster carer arrangements. C74 took an overdose.
17.05.17	CAMHS crisis team review completed by CP4 following a self-referral by C74. CAMHS agreed further support and intervention.
18.05.17	C74 did not attend a psychiatric appointment. She was taken to an Emergency Department (ED) from college due to self-harm. Assessment completed by another CAMHS worker and she was discharged with agreed follow up by the crisis team.
15.06.17	Social Care – The Child Looked After (CLA) team record entry states that C74 is engaging well with the CAMHS crisis team (Weekly appointment with CP4). Comment recorded that C74 liked the approach of CP3 and CP4.
16.06.17	CP4 held a crisis team follow up session with C74 which was focused on coping strategies to replace self-harm.
26.06.17	Record entry by C74's college stating that C74 had told her foster carer that she no longer wants to engage with CAMHS as she does not want to move workers. She says that she has opened up to CP4.
27.06.17	Foster Carer telephoned CAMHS explaining that C74 no longer wants to engage with CAMHS.
	Joint visit between Social Care (CLA) team and CP4 to see C74 at her college. Record states that 'in terms of further engagement with CP4 or CP2, I'm not sure how this would work so I have contacted my manager to discuss'.
	Records indicate that C74 had wanted continuity in those from CAMHS that were looking after her. It would appear that she specifically requested ongoing support from CP4 or CP2.
08.07.17	C74 taken to hospital by carer due to self-harm.
10.07.17	Email to CAMHS from social worker raising concerns that C74 did not want to engage with new worker. They requested that she was seen either by CP4 or one other named worker. Decision was that CAMHS crisis team were unable to offer the support that was requested. Plan was to attend a social care meeting to discuss options.
11.07.17	C74 agreed to work with CP5 but not until after the college holidays. College records state that the plan was for CAMHS support to take a break as C74 was not keen on having a new worker. Crisis team to continue support of carer and C74 in the meantime.
	There was a clear desire by all agencies involved to provide continuity in the support services that were provided to C74 due to the mistrust that she had of other professionals. Professionals were also listening to what C74 wanted.
01.08.17	Psychiatric review. C74 attended with her foster carer. C74 presented as angry when asked about her wellbeing. C74 stated that she did not want to come to CAMHS any longer as every time she attended nothing changed. She stated that she would 'rather kill herself than be in the CAMHS office' (ECM progress report dated 20/08/17).

11.09.17	C74 did not attend an arranged appointment with a CAMHS tier 3 worker. Her foster carer was unsure why this was and felt that she was in a low mood. A safety plan was discussed and another appointment offered.
19.09.17	Admission to hospital due to suicidal ideation. Crisis assessment CP4 agreed to work alongside C74's tier 3 worker. C74 was discharged home and a follow up appointment arranged.
23.09.17	Crisis assessment following an admission to ED as C74 had self-harmed (22.09.17) and had taken an overdose. She was not medically fit for discharge.
26.09.17	Discharge meeting held. Placement had broken down with carers.
27.09.17	Appointment with CAMHS psychiatry. C74 having increased suicidal ideation. Plan agreed for an informal admission to a Tier 4[35] unit.
27.09.17	SW1 disagreed with the discharge plan. In their professional opinion the level of risk and the plan to send C74 home was not sufficient as foster carers and the LA could not maintain her safety. C74 taken to a Tier 4 unit by a crisis worker.
02.10.17	Discharge meeting held. CP4 updated records to state that C74 would be discharged from tier 4 facility to temporary foster care placement. Crisis team to offer daily home visits. Mental health reviewed and safety plan agreed.
03.10.17	Entry by Social Worker states that C74 was in a poor state, tearful pale and in a distressed state.
04.10.17	Crisis team session held at college with CP4.
09.10.17	CP4 telephoned carers of C74 and stated that there would be no visit that day. Also spoke to C74.
10.10.17	Crisis team session held at college with CP4. Entry states that the session was focused on sleep, hygiene and space for reflection on recent events.
12.10.17	Crisis team session held at college with CP4.
13.10.17	Crisis team session held at college with CP4.
16.10.17	Crisis team session held at college with CP4. Focused on coping strategies and alternatives to self-harm.
17.10.17	Crisis team session held at college with CP4.
19.10.17	Entry in records by C74's social worker which states that ' due to C74's risk assessment in the interim a high level of support will continue to be provided to her carer through children's services and CAMHS.
23.10.17	CAMHS received a telephone call from C74's carers stating that she had self-harmed and was refusing to go to a GP. CAMHS sent CP4 as C74 appeared to trust him.
10.11.17	Crisis Team session risk review with CP4.
13.11.17	Crisis Team session with CP4. Focus was on upcoming meeting with new foster carers.
14.11.17	Crisis Team session risk review with CP4. C74 expressing anger at SW1 and new foster care arrangements.

[35] An acute general adolescent unit for the admission of young people to be when they need inpatient mental health care. Young people can be admitted on a formal (sectioned) or informal (voluntary) basis.

15.11.17	College records show that CP4 had a student meeting with C74. CAMHS records state that CP4 attempted to contact social worker but no contact was made.
17.11.17	Crisis team session held at college with CP4.
21.11.17	CP 3/4 met with new carers. They advised them of their ongoing involvement and provided contact details.
24.11.17	College records state that CP4 attended the premise to conduct a crisis session with C74.
	CAMHS records state that it was in fact CP3 that met C74.
27.11.17	C74 admitted to hospital having taken an overdose.
28.11.17	CP4 attended the hospital to see C74 by CP4. He was accompanied by a CAMHS team leader.
03.12.17	Crisis team session community intervention[36] with CP4.
06.12.17	CP4 text his supervisor to say that his child was sick and he wouldn't be in. He stated that he would be back tomorrow.
07.12.17	SW1 went to see C74 and discussed the issues regarding her recent overdose. The Social Worker met CP4. He wanted to meet with C74 on her own and then invited the Social Worker to join them after five minutes.
08.12.17	CP4 collected C74 from college for a psychiatric review.
10.12.17	CP4 carried out a home visit. SW1 was present. Crisis team intervention took place in the community. The focus was on future thinking and a 'life worth living'.
12.12.17	Crisis team session held at college with CP4.
20.12.17	CAMHS received a call from C74's foster carers stating that she had self-harmed and left home. CP4 met foster parents. Calls made to C74 and CP4 agreed to go and collect her. Records state that he discussed boundaries, communication and coping strategies.
	Police believe this to be the first time that sexual intercourse took place.
21.12.17	Crisis team session held with CP4 in the community.
22.12.17	SW1 conducted a statutory visit. C74 was described as settled and talking about age appropriate things. Records state that she was 'very excited that CP4 will be visiting her on Christmas day.
25.12.17	Crisis team session. Intervention in the community. CP4 reviewed risk and agreed to increase visits due to increase in suicidal thoughts. Coping strategies were discussed.
	CP4 was working over the Christmas period and therefore following the agreed plan regarding visits. This was raised as part of the review with CAMHS but was not thought to be unusual.
26.12.17	Intervention in the community by CP4.
27.12.17	Intervention in the community by CP4.
28.12.17	CP4 carried out home visit after taking her to a psychiatry review.
29.12.17	CP4 carried out home visit. He attended the pharmacy with C74 for a prescription.
	Records of foster carer supervision state that C74's carers had stated that CAMHS had been really helpful over the Christmas period.

[36] Community intervention involves taking the young person out for some kind of activity.

04.01.18	CP4 held crisis team session held with C74.
05.01.18	CP4 called C74 as she was stressed after contact with her mother.
06.01.18	CP4 held crisis team session with C74. Discussion held with foster carers. Intervention in community offered.C74 asked for appointments after college.
10.01.18	CP4 held crisis team session with C74 in the community. Plan was for C74 to be seen by CAMHS every other day (record of foster carer supervision).
12.01.18	CP4 held crisis team session with C74 and her foster carers at her home address. C74 disclosed some self-harm over the past few days. Intervention on the community. The focus of the session was on being isolated.
14.01.18	CAMHS worker spoke to C74 on the phone. C74 reported being isolated and staying in bed more. She stated that she felt unwell. Home visit planned.
17.01.18	CP4 picked up C74 from college to transport her to a psychiatry and medication review.
18.01.18	C74 taken to a GP by foster carers as she wasn't feeling well. She refused to let the GP touch her. Foster carer showed the GP where the pain was. Diagnosed as an infection and antibiotics prescribed.
19.01.18	Telephone call made by CAMHS to foster carers to arrange an appointment. Informed that C74 was unwell.
29.01.18	CP4 held crisis team session held with C74 in the community.
29.01.18	CAMHS Supervisor spoke with CP4 regarding him returning late from appointments and the impact that this had on the team. CP4 denied that this had occurred. A discussion took place regarding the importance of putting notes on system, of transparency, and about being open and honest. The supervisor states that she expressed her frustration and disappointment regarding his lack of response.
31.01.18	CP4 left morning handover early stating that he had to pop out. Arrived back approximately 30-40 mins later. When asked where he had been he stated that he had to put fuel in his car and check his tyre pressures. He was challenged re inappropriate use of his time.
31.01.18	Incident in college. C74 locked herself in a toilet and was upset and crying. She stated that she wanted to be alone. College staff supported her and encouraged her to come out.
04.02.18	CP4 made a telephone call to C74's foster carers to arrange a crisis team appointment.
05.02.18	CP4 held crisis team session with C74 in the community.
06.02.18	CAMHS supervisor received a text message from CP4 stating that he wouldn't be in that day due to a migraine.
06.02.18	C74 disappeared from the student room in college. She was upset. When spoken too she stated that there wasn't a problem in college and could not say what had upset her.
08.02.18	CP4 took the day off due to a migraine. Not reported in as per the sickness protocol.
12.02.18	CP4 challenged by his supervisor regarding a failure to complete forms correctly. He later text her stating that he had an appointment the following day at 3pm and that he would be going straight there. He had been due in at

	2pm. His supervisor text back to ask what it was for and he replied it was a medical appointment and he would be in between 4 and 5pm.
12.02.18	CP4 called C74 to arrange an appointment. C74 stated that she was unwell and that the appointment be cancelled.
13.02.18	Crisis team visit to C74's home address by a CAMHS worker. Care plan discussed. The two male staff who had supported C74 (including CP4) went to visit her to say goodbye as they had regularly seen her. Notes state that C74 stated that 'I'm Ok' as if to decline the visit. C74 discharged from crisis team.
13.02.18	CP4 had arrived late into work (18.30hrs) – CAMHS Crisis team worked 0900-2200hrs Monday to Friday and 0900-1700 on weekends. There had been no communication from him to his supervisor prior to that.
14.02.18	C74 attended a Sexual Health Walk in Clinic. She was seen by a doctor and she informed them that she thought that she might be pregnant. Gestation period six weeks (Around 3rd Jan 2018)
14.02.18	Health visitor informed social worker of pregnancy. Records state that C74 stated that she had sex with a boyfriend (unnamed), it was consensual and both were of legal age.
15.02.18	CAMHS spoke to foster carer following a report that C74 didn't want to attend an appointment. Foster carer stated that C74 had returned home from college and had gone to bed with a headache. Agreement that she would attend another appointment planned for the following week.
16.02.18	C74 disclosed to her college that she was pregnant.
26.02.18	CP4 moved from the crisis team to Tier 3 provision.
08.03.18	Child in Care review. C74 was reported to have been settling in well with her foster carers.
15.03.18	IRO meeting held. No mention of the pregnancy
16.03.18	C74 revealed that she was being sexually abused by CP4.
20.03.18	C74 attended the Sexual Assault Referral Centre (SARC) where she received the appropriate medical attention and signposting.

Glossary

CAMHS - Child and Adolescent Metal Health Services
CIN – Child in Need
CLA- Child Looked After
CRHTT - Crisis Resolution and Home Treatment Team
CYPS- Children and Young Person Services
DASH- Domestic Abuse, Stalking and Honour Based Violence risk assessment
DSL – Designated safeguarding leads.
ED – Emergency Department
FACE - Functional Analysis of Care Environments
FIT – Family Intervention Team
GSC- Government Security Classifications
IDVA- Independent Domestic Abuse Adviser
LAC- Looked after child
MARAC – Multi Agency Risk Assessment Conference
MASH- Multi Agency Safeguarding Hub
MOC – Mother of the child
NHS – National Health Service
NMC – Nursing and Midwifery Council
PARIS – Primary Access Information System
PCT- Primary Care Trust
SHA- Strategic Health Authority
TAF- Team Around the Family
THRiVE - Truancy Habits Reduced Increasing Valuable Education.

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