Bradford BSCB Safeguarding Children Board

Autumn

A Serious Case Review Based on the Partnership Learning Approach

For Bradford Safeguarding Children Board

Independent Chair: Prity Patel

Independent Author: Brian Lawson

6th December 2016

Foreword

The purpose of inquiring into critical incidents as part of a Serious Case Review is to promote learning and understanding in order to develop practice, services, systems and governance. In order to do this we need to understand the context of practice and service delivery at the time and try and avoid working from the benefit of hindsight. The focus is to shed light on particular previous practice in order to illuminate our current reality and connect the journey between the two in a meaningful way.

Any systemic failure has a complex and particular causality. Some of it, as the Serious Case Review into Child Sexual Exploitation in Oxfordshire (2015) concludes, relates to a general context and moment in the wider coming to terms with sexual exploitation as a society and as a culture.

Equally some of the issues reside in the particular and local contexts in an individual case. They reside in the experiences of a child, in their family and in their own strengths and resilience. They lie in the dynamics and risks in the communities they find themselves in; and in the history and development of the services which support that community and provide welfare and safeguarding support for children and their families.

Outcomes in individual cases are also uniquely dependent on the leadership and management of organisations. This is managed through the co-ordination and robustness of systems, policies, procedures and processes and information sharing arrangements in place which support frontline practice. The nature and history of the relationships between the people who discharge these responsibilities, in a practice area, will also have an impact on how a case develops. Outcomes depend on the nature and robustness of assessments and how they are shared. They also rely on how well critical information is communicated through the system, retained and utilised as knowledge within plans and interventions.

In the final instance outcomes are also dependent on the individual choices, decisions, understanding, knowledge, skills and commitment of individual practitioners and how they are supported, and in consequence, how they are enabled to take responsibility for their assessments and interventions, both individually and collectively.

Following the threads of a single case over time and seeking to weave these themes together we can create a tapestry which illustrates what happened over Autumn's journey. We can use the process and the experience and knowledge gained to reflect on current practice. In order to deepen our understanding, the picture created is explored from a number of different perspectives. These perceptions illustrate how the same information can be seen or interpreted differently by individuals. Whilst this may seem repetitive it is important to understand how individual professionals respond differently, how different perceptions are shaped over time and how this informs comprehension and action. As we will see, a number of threads are lost during the interventions, others gain undue weight, and others are picked up in one place and not another. This makes the story challenging to follow at times. A detailed table of contents is provided to assist the reader in navigating the breadth of the terrain covered in this report.

Whilst practice, both on a multi-agency and single-agency basis was informed and developed by the experience of working with Autumn and her family, this was only a single thread in a more complex picture. This included the range of other casework for the practitioners and managers concerned, and the development of research, policy and practice responses over time. This broader context is also captured and referred to in the narrative.

Urinary incontinence, both during the day and at night time, was a consistent feature of Autumn's experience along with occasional soiling. In the text we use the term enuresis to refer to all aspects of

urinary incontinence. The terminology surrounding wetting and soiling is explored in more detail as part of the recommendations in the report.

In producing this report, which seeks to capture as simply as possible a complex, dynamic and emergent story with a single thread and a broad perspective over time, my thanks are due to the following people:

- Autumn for her contribution to the review and her detailed comments on a final draft.
- Autumn's immediate family for their time and contribution to the review.
- The practitioners and first line managers who worked directly with Autumn during this journey. For their contribution to the narrative, their assistance in helping me form a view and their contribution to identifying what should be done and developed in relation to current practice as a result. They have contributed by attending the two learning events and individually in more detailed interviews.
- Managers and others who completed Independent Agency Reviews, those who contributed to the learning events, and to the work of the Panel.
- The members of the Review Panel for their robust commitment to ensuring that we clearly identified and explored the issues and what we could learn from them. Also for their engagement in key debates on a range of issues and their assistance in clarifying my thinking.
- The Independent Chair of the Panel, Prity Patel for her robust and focused chairing of the Panel and for her clarity of thinking and insight in providing guidance and support to me in the completion of this review.
- The BSCB business manager, the SCR administrator and other staff who have provided support to the Review and ensured that things ran as smoothly and in a timely way as possible.
- Professor Jenny Pearce at the University of Bedfordshire who acted as expert research advisor to the Panel.

Having said all of this and acknowledging the level of challenge, co-operation and collaboration involved in completing this report, the comments and content are mine as the Independent Author.

Brian Lawson – Independent Author

Table of Contents:

1. Executive Summary and Introduction: - This review is about Autumn and her experience of Abuse, Neglect and Child Sexual Exploitation:

Autumn grew up in a fractured and reconstituted family in a town which reflected her issues of identity and culture. She had a difficult relationship with her mother which often lacked warmth and attachment and her relationship with her stepfather was often difficult. Autumn' had regular contact with her father which was, at times, prohibited by her mother. Her father suffered with asbestosis and drank heavily and in later years this relationship was shadowed by his diagnosis of a terminal condition. Autumn's consistent support came from her grandmother to whom she turned in times of difficulty and estrangement. As a result, Autumn developed a pseudo maturity and independence which resulted in Autumn taking decisions and making choices for herself which were often not in her best interests. These circumstances created one aspect of a constellation of vulnerabilities for Autumn.

In addition to the emotional issues and attachment impacts that Autumn experienced, she reported on several occasions that her mother had been physically abusive to her. In addition, Autumn's health needs for assessment and treatment for her incontinence and soiling symptoms were never followed through by her mother. This increased Autumn's vulnerabilities significantly, through the effects of her symptoms on her confidence, self-esteem and self-worth, effectively isolating her from her peer group. The impact of Autumn's situation was to steer her into situations where she sought affection, leaving her vulnerable to abusers who pursued, groomed and sexually exploited her. The perpetrators eventually exercised total control over Autumn. They achieved this through an escalating and relentless series of physical and sexual assaults and threats to her and her family.

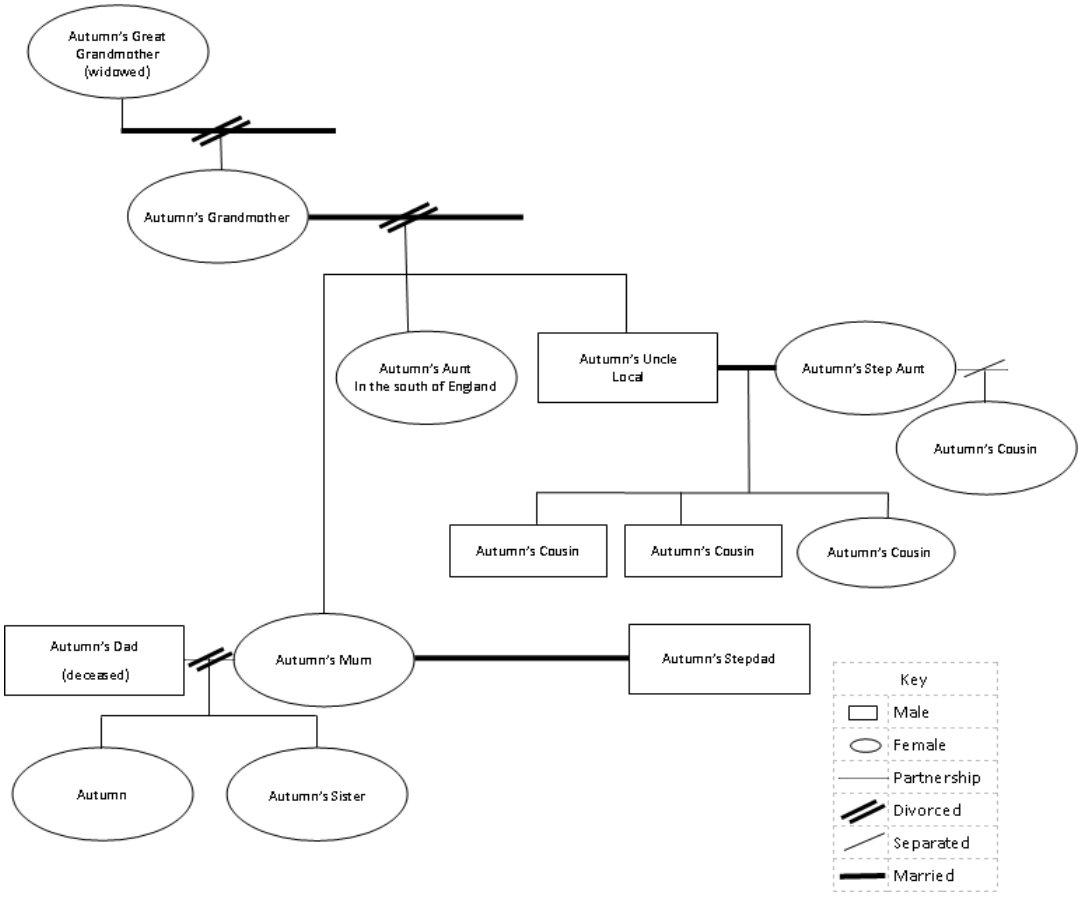
Different agencies held a range of information which identified Autumn as a child at risk of harm, but this was tempered by perceptions that Autumn was a child who withdrew her allegations or said she had lied. These records were not fully shared across the partnership in line with safeguarding procedures or practice expectations, in a professional and meaningful manner and never resulted in a formal or child protection investigation or medical. Autumn became disillusioned about professional's abilities to end her abuse.

Autumn's case was directed into the Child in Need system as a result of the lack of appropriate information sharing, her mother's responses to Autumn's allegations and a shared professional perception of Autumn as a child with behavioural issues. The risks to Autumn were never fully analysed and understood, nor was the harm she was experiencing recognised. This resulted in interventions being put in place that were ineffective, and allowed the perpetrators to go on abusing Autumn, and she continued to suffer harm for a further 12 months following her first disclosure of rape in May 2011. This disclosure was made to three agencies none of whom disclosed this information to Specialist Children's Services at the time..

From November 2011, Autumn's case was also being discussed at a strategic level and flagged as high risk and of the highest priority. These parallel processes worked in isolation and there was a lack of realisation, as well as conflict, within and between agencies of the significant differences in professional judgements being made about Autumn's need for protection and safeguarding. This was further exacerbated by how Autumn's case was perceived at the front line, across the partnership. There was confusion and misunderstanding about each agency's roles and responsibilities, which system the case was being managed under, and the status of meetings that were taking place. The language and organisational culture at the time played into Autumn's behaviour being perceived pejoratively and her family as co-operative. This resulted in Autumn's case not following a child protection pathway. Although agencies held information that identified Autumn as a child at risk of harm, almost from the first concerns raised about child sexual exploitation, this was not acted on.

The level of risk to Autumn was acknowledged by the police and her school in November 2011 who wanted action taken to secure Autumn's safety away from her perpetrators. This was strongly resisted by Children's Specialist Services who believed that Autumn's case did not reach the threshold of child protection as the family were actively involved in her Child in Need plan. They supported her living with her maternal grandmother. Risks continued to escalate for Autumn and more effort was made to support her in her family. Following the Police gathering sufficient evidence to arrest alleged perpetrators it was recognised that Autumn could only be protected by moving her away from her local area. Eventually she was placed in a residential unit with the agreement of her mother. Autumn settled into this placement which was supported by her family and a range of agencies. She was able to engage with learning again, make friendships and pursue interests at which she excelled. Two years into her placement just prior to her GCSEs Care proceedings were issued to secure Autumn in her placement, but these were opposed by Autumn and her family and resulted in the court making No Order. Autumn was able to provide detailed evidence whilst in the placement which was supported by the family and a range of agencies. Following a difficult trial for Autumn 12 males were found guilty of various sexual offences and received sentences totalling over 140 years.

2. Autumn's story:



2.1 Autumn's early upbringing, her enuresis, her family context and attachments, her cultural identity and where she lived all converged to create a particular vulnerability within a complex and evolving dynamic. This constellation of circumstances and characteristics was never brought together and understood in context as part of any individual or multi-agency assessment whilst she was living in the Bradford area. There were significant issues of harm, conflict and rejection in Autumn's relationship with her mother which resulted in her making three disclosures of physical assault and in her spending two periods of time living in the care of her grandmother. Autumn's mother and stepfather took a holiday in October 2011 without Autumn and her sister,

which resulted in Autumn moving in to live with her grandmother on a permanent basis. Whilst Autumn's grandmother provided love and care for Autumn, she was not able to support her school attendance or prevent her missing episodes from escalating.

2.2 There were consistent attempts made by a range of agencies to provide coordinated support to Autumn and her family during 2010 and 2011. A number of individuals were particularly committed to supporting Autumn during this time. However confusion about systems and processes over this period, a lack of understanding about the risk Autumn was exposed to, and a number of failures to follow existing policy and procedure led to a system failure and to a delay in protecting Autumn from the significant harm she was subject to during this time. Autumn was recorded as missing 70 times between March 2010 and May 2012.

2.3 The period between January and May 2012 saw a more intensive criminal investigation with a forensic focus which involved more specialist officers and more resources. This period also saw conflict between Police and Social Care in relation to the safest place for Autumn to live.

2.4 Autumn was eventually accommodated away from the Bradford area in June 2012. The Police continued their investigation into the alleged perpetrators, undertaking detailed interviews with Autumn whilst she was in her residential placement. The support provided by the residential unit to Autumn was good and this was supported by consistent coordination from Children's Specialist Services in Bradford, West Yorkshire Police, by Autumn's family and later on by Barnardos. Autumn was supported to take up other interests, to continue her Education, to have her health needs assessed and addressed and to make other significant progress.

2.5 There were still concerns about Autumn going missing whilst in her residential care placement. There were flaws in the processes, rather than the outcomes, of determining and securing Autumn's accommodation away from Bradford by the Local Authority. These are evidenced in relation to the consideration of Autumn's placement with her maternal Aunt, and in the issuing of formal proceedings in the spring of 2014. The Legal advice taken in relation to these decisions from the Local Authority Legal Services was not clear or consistently recorded. Practice has been improved in this area as a result of this review.

2.6 Concerns and issues about Autumn were picked up early and persistently, although not in a way which resulted in the harm to Autumn being recognised and acted on to safeguard her. Whilst services were responsive and engaging there was a lack of focus and recognition of the degree of harm Autumn was exposed to in the assessment and the co-ordination of services. Autumn's Educational journey was actively preserved post placement and she was supported to recover, develop and achieve in a co-ordinated way at the residential placement.

2.7 The co-ordination of care, support and investigation was planned and co-ordinated by both operational and strategic partnerships: through regular Looked After Children reviews, overseen by an expanded Gold command in Bradford, led by West Yorkshire Police.

2.8 Within the deficiencies and missed opportunities identified, individuals and services stayed engaged in supporting Autumn and her family and were eventually successful and effective in safeguarding her from further harm and bringing the perpetrators to justice.

3. Why this serious case review was conducted:

The statutory basis for conducting this serious case review (SCR) and the role and function of the BSCB is set out in law by:
The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90.
Regulation 5 requires the BSCB to undertake a review where –

a) Abuse or neglect of a child is known or suspected: and
b) Either –

i) The child has died: or
ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Guidance for Local Safeguarding Children Boards conducting a serious case review is contained in Chapter 4 of 'Working Together' 2013 and reviewed in the 2015 guidance.

4. Methodology of the review:

The panel agreed that the review would be conducted using the Partnership Learning Review (PLR) framework, adapted to meet the needs of Bradford. This process, which can be used to conduct Serious Case Reviews and which is in keeping with the principles prescribed by Chapter 4 of Working Together March 2013 ensured that:-

- A proportionate approach to a SCR, according to the scale and level of complexity of the issues being examined,
- All SCRs to be independently led
- Professionals who were directly involved with the case to be fully involved in the review process
- Families, including surviving children to be invited to contribute

The review was conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- Is transparent about the way that data is collected and analysed; and
- Makes use of relevant research and case evidence to inform practice.
- Is young person focused and sees the young person in their context and lived experience. This review looks at Autumn's journey through life and services.
- Focuses on learning, resulting from the rigorous and objective identification of good and poor practice arising from the engagement and reflection of involved professionals in the learning events.
- Focuses on the promotion of resilience in systems, organisations and staff through the process of learning and the development of practice`.

4.1 Setting up the review using the PLR framework:

4.1.1 The criteria for a Serious Case Review were met in this case in line with the requirements in WT 2013 and the case was initially considered by the LSCB's SCR sub group. Having agreed that it was appropriate, the SCR sub group recommended to the LSCB Chair that an SCR was needed.

4.1.2 The size and make-up of the SCR panel was agreed by the SCR sub group, and an expert in the field of CSE research was co-opted into the panel to provide expert advice throughout the process.

4.1.3 An independent person was appointed as the Independent Safeguarding chair to the panel, and given the complexity of the case a separate independent Overview Report author was also commissioned.

4.1.4 The time period covered by the review was identified to reflect the potential learning that was to be achieved. This was balanced however with the need for example to understand the chronology of child neglect and CSE, and whether early help or other interventions could have been beneficial. The process actively involved practitioners and their managers

4.1.5 All those agencies who provided services to the family for the time period to be covered by the review were formally requested by the LSCB Chair, to appoint their Individual Agency Representative to complete a report and chronology of their agency's involvement, and of any organisational changes over the same period of time, which may have impacted on front line practice. A chronology template was provided.

4.1.6 The review was based on the key stages of the PLR as follows:

- Information collection and collation.
- Establishing the Themes for Analysis.
- Preparation for the Learning Event with practitioners.
- The first Learning Event – workshops focused on the terms of reference..
- The completion of the first draft overview report.
- The second learning event – workshops focused on the emerging themes.
- Finalising the process – final overview report presented to the BSCB.
- Feedback to the family.

4.2 How this Serious Case Review was conducted:

4.2.1 Two independent reviewers were commissioned to lead the review. The author/lead reviewer, Brian Lawson was commissioned in April 2015 to conduct this review due to his previous experience of writing Serious Case Reviews and Domestic Homicide Reviews. He also has relevant experience working with Safeguarding Children Boards and with Child Sexual Exploitation. Prity Patel, Chair of the review/Lead reviewer has over 20 years' experience as a senior Child Protection Lawyer, both in the private and public sector. Miss Patel has overseen a substantial number of serious case reviews both as chair and author. Both parties are independent of Bradford Safeguarding Children Board in accordance with Working Together 2013 Chapter 4 (9).

4.3 Members of the Review Panel:

The panel was regularly consulted about the progress of the review. Issues arising were discussed within a Bradford context, and the panel were able to provide further information where appropriate. The panel included a lead member from each of the key agencies listed below:

- Independent Lead Reviewer (Chair): Prity Patel
- Independent Lead Review (Author): Brian Lawson

- Bradford Safeguarding Children Board - Board Manager:
- Bradford & District Clinical Commissioning Group Designated Doctor
- Bradford Metropolitan District Council Children's Specialist Services Group Service Manager
- Bradford Metropolitan District Council Access and Inclusion Service Behaviour Support Manager
- Bradford & District Clinical Commissioning Group Designated Nurse
- West Yorkshire Police Detective Superintendent Homicide and Major Enquiry Team
- Barnardos Assistant Director
- Independent Expert Adviser: Professor Jenny Pearce – Bedfordshire University
- Bradford Safeguarding Children Board Legal Advisor
- Bradford District Care Foundation Trust Named Nurse for Safeguarding

Date of Panel Meeting:	Panel Meeting:
8th.June 2015	Author's briefing to IARAs
16th.July 2015	IARA workshop and practitioner event
11th.September 2015	Panel meeting
12th.October 2015	Panel meeting
30th.November 2015	Panel meeting
25th.January 2016	Panel meeting
7th.March 2016	Panel meeting
12th.April 2016	Panel meeting
26thMay 2016	Panel meeting
20th.June 2016	BSCB meeting

4.3.1 Independent Agency reports, chronologies and additional information provided to the Review:

Agencies were asked to compile a report detailing their contacts with the principles in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and of good practice. Where appropriate, an action plan, detailing those areas for improvement and the work being undertaken to address those issues was included. All of the agencies that were asked for a report provided the information requested. In cases where further clarification was required, agencies responded in an open and honest way.

IA Reports:	Chronologies:	Additional Information:
Airedale Hospital	Airedale Hospital	1st. draft Overview report (OR) November 15
BRI	Bradford Royal Infirmary(BRI)	Initial Board draft OR 7th.March 2016
CSS	Children's Specialist Services(CSS)	Final Board Draft (OR) 20th.June 2016
School	Secondary School	
WYP	West Yorkshire Police (WYP)	
BDCT	Bradford District Care Trust(BDCT)	
GP services	GP services	
Barnardos	Barnardos	
Hexagon Care	Hexagon Care	
CAFCASS	CAFCASS	
Access & Inclusion	Access and Inclusion	
PACE		
Children's Society		

4.3.2. Dates of Interviews and learning events:

The learning events with front line practitioners and first tier managers are an essential part of the process. In the first learning event, staff that had contact with Autumn and her family were brought together for discussions around themes that had been identified from the chronologies and reports. This engagement provided a view of autumn and her family dynamics that enriched the information provided by the agencies and ensured that all of the relevant facts were recorded. It was the most effective way of triangulating the evidence and ensuring that an accurate picture of the life of Autumn was obtained.

This review seeks to determine why events have occurred and not just record the facts of what happened. The front line view is invaluable in achieving this.

Whilst the details of discussions that took place were recorded, the comments made by staff involved were non attributable and their comments are not quoted directly in this report. For many front line practitioners this was the first opportunity for them to discuss with other professionals their engagement with the family; it was pivotal to the learning from this review.

The second learning event brought professionals back together along with more senior managers and representatives from across the BSCB. They were presented with the key findings and recommendations and provided with an opportunity to discuss them, contribute to and shape them based on their experience and comment on their accuracy and validity.

Following further discussion at the Review Panel on the 8th June 2015, it was agreed that the author would undertake a further set of interviews. These interviews would be with key professionals from a range of organisations with experience of working in the context of Autumn's home community. This was deemed necessary for the author to develop an understanding and knowledge of the particular context of the community in which Autumn had grown up.

Date of meetings:	Interviews and Learning events:
30th.June 2015	1st. Learning event
23rd.February 2016	2nd. Learning event
4th & 5th.August 15	Interview with Professionals – Autumn's local area WYP x 2 Designated Doctor x1 LA x 1 CSS x 3 BSCB x 1
4th.August 2015	Interview with Autumn
4th.August 2015	Interview with Autumn's family
4th.May 2016	Interview with. Autumn

4.3.3 Family Engagement:

The author had two meetings with Autumn, one in the presence of the head of the residential unit, and the second in the presence of a friend. The author also met with her family on two occasions. Autumn gave a detailed interview and commented in detail on the report. Her family also contributed to, and commented on, an early draft. The concerns that they identified were explored in the review and the findings and conclusions about these were fed back to them. This ensured that Autumn and her family were able to contribute fully to the discussions around the themes, issues arising from the chronologies and reports, and bringing their own perspectives to these.

4.3.4 Parallel Investigations:

A meeting was held on the 9th May 2015 with the LSCB manager and the senior investigating officer from West Yorkshire Police in the criminal case. An agreement was reached on the boundaries between the Serious Case Review, the on-going investigation and the trial. The trial was provisionally booked for November 2015. The conversations were informed by the guidance for Police, Crown Prosecution Service and Local Safeguarding Children Boards: '*Liaison and information exchange when criminal proceedings coincide with Serious Case Reviews'* as required by "Working Together to Safeguard Children" (2013).

The outcome of this meeting was reported to the Panel on the 8th June and it was agreed that the Serious Case Review could proceed in parallel with the criminal investigation and the trial. It was agreed that there would be close liaison between the agencies to support clear boundaries between the two processes. In particular, in relation to the Learning Event proposed on the 30th June 2015 and the interviews with Autumn and her family planned for July 2015.

4.3.5 Policy and Research Expertise:

It was also agreed that access to policy and research for the Serious Case Review would be provided by Jenny Pearce, Professor of Young People and Public Policy at the University of Bedfordshire: Professor Pearce is also the Director of the University's International Centre: Researching child sexual exploitation, violence and trafficking.

4.4 Terms of reference for the review (TOR):

The Panel met on the 8th June 2015 to confirm the terms of reference, the methodology to be used and agree the timetable for the review. The terms of reference were derived from the initial chronologies submitted by the nominated agencies. The overview author also met the majority of the Independent Agency Review Authors (IARAs) with the Chair on the afternoon of the 8th June 2015. The IARAs were identified from each relevant agency from those managers who had no dealings with Autumn's case, and were asked to prepare a chronology and report outlining their agency's involvement with Autumn and the services offered to her. The meeting was held in order to conduct an Author's briefing so that Individual Agency Report authors were fully appraised regarding the methodology to be used for the review and the terms of reference identified.

4.4.1 This Serious Case Review, based on the Partnership Learning framework, will inquire into:

- The provision and coordination of support and safeguarding services to Autumn and her family between January 2010 and June 2012.
- The type of abuse Autumn suffered and the nature of the perpetrators involved.
- The coordination and support provided to Autumn and her family following her accommodation in June 2012 to the conclusion of formal care proceedings in September 2014.
- The impact of Autumn's development and identity in her family and community context in relation to her vulnerability and risk.
- What can be learned from these experiences to inform current practice in the context of relevant research and policy development.
- The current and developing practice, service and strategic response to CSE in the Bradford District.

4.4.2 A summary process and timetable for the Serious Case Review:

- The setting up of the review reflects the background as described in chapter2, and was completed by June 2015.

- A challenge to the timetable, resulted from - changes in structure in certain agencies, the identification and availability of IARAs and ensuring compliance with the criminal process; the process of Information collection and collation, Independent Agency Reviews, detailed Chronologies, interviews and other evidence and research identified, was completed in January 2016.
- Preparing for and facilitating the first learning event that was held on the 30th June 2015.
- Reviewing the independent agency reports and gathering any further evidence took place during September 2015 and January 2016. Again, delays were experienced in the process due to changes in personal as panel representatives, different versions of the report being produced and the late production of an IAR.
- Completion and discussion of the first draft overview report took place in November 2015.
- Preparing for and facilitating the second learning event that was held on the 23rd February 2016
- Completion of an initial Board draft was completed prior to the second learning event and the panel meeting on the 7th March 2016.
- The final Board draft was presented to the Bradford Safeguarding Children Board on the 20th June 2016. The publication of the report was considered at this meeting.
- Initially, the review was to run from June 2015 to December 2015. This was kept under review, and the review was then extended to February 2016 to allow for the criminal trial to take place. The review was further extended to June 2016 at the Review Panel held on the 25th January 2016

4.4.3 Final Terms of reference:

The final terms of reference and timescale for the review, were finally agreed after the practitioner event at the IAR Author workshop, run on the 16th July 2015.

4.4.4 Timescale for the review:

4.4.1 The review will cover the time period from the 1st January 2010 to the 30th September 2014. This time period has been selected from the preliminary information provided to the Review panel. It was from 2010 that significant events started to occur leading to concerns by professionals about Autumn's behaviour and welfare.

4.4.2 The Review Panel considered that there was further learning to be gained from the period after Autumn was accommodated by the Local Authority on a section 20 placement, until an application for a full care order was heard. The timeline was therefore extended to September 2014. It was also agreed that further contextual information relevant to the terms of reference prior to 2010 should be included where appropriate and if suitable learning was identified. .

4.5 Themes identified as part of the TORs: Subject, family, community and organisations:

4.5.1 Describe and analyse Autumn's journey and experience in the context of her immediate family, peer network and within the context of her home town community.

4.5.2 Describe and analyse Autumn's emotional state and response to her experiences, as well as her behavioural reactions. This should include an assessment of her family attachments and the extent of her engagement with staff and workers from a range of agencies. This should be assessed in the context of any known threats, intimidation and coercion or grooming Autumn and her family may have been subject to by the alleged perpetrators, as understood at the time.

4.5.3 Describe and analyse issues of culture, ethnicity and identity within the immediate family and the local community and how this informed agencies' relationships with the subject and the family.

4.5.4 Describe and analyse the way in which organisations, identified as part of the review, interacted and worked with the subject and her family and with each other. Consider these interactions in the organisational contexts and of the policy and procedural frameworks that applied at the

time. In addition, the author should analyse the impact on the family, intended and unintended, of these interactions with professionals and organisations.

4.5.5 Describe and analyse the level of understanding about child sexual exploitation operating at national, local and organisational levels and how this changed and developed over the timeframe of the review.

4.6 Focus of the Learning Review: Key periods in Autumn's journey:

There are six key periods which the review will focus on. These are:

4.6.1 Any relevant information in relation to family, peer and community issues and dynamics in the period prior to the 1st January 2010.

4.6.2 The period from January 2010 to the spring of 2011. In particular, the underlying concerns around Autumn, and her patterns of behaviour, and how these were picked up by agencies and communicated appropriately.

4.6.3 The period from spring 2011 to December 2011 when concerns escalate.

4.6.4 The period from December 2011 to February 2012, which appears to be a time of stability for Autumn.

4.6.5 The period from February 2012 to May 2012 when there is a more structured approach to her placement with Grandmother, and active consideration about moving Autumn away from Bradford.

4.6.6 The period from May 2012 until September 2014 - this includes accommodation away from Autumn's home town and the subsequent proceedings.

4.7 Focus of the Learning Review: Contemporary focus on culture and effective practice:

4.7.1 Given the legitimate public interest in the review, the review should also have a focus on current issues and developments in relation to Child Sexual Exploitation.

4.7.2 In particular, given the concerns identified in relation to Rotherham and other places, the review should take a view on whether there is any denial in agencies and organisations in relation to identifying and intervening into situations of Child Sexual Exploitation; the effectiveness of current safeguarding practice and interventions and the development of a broader range of interventions as described by Louise Casey in her reflections on Rotherham.

4.7.3 This review will not inquire into any other historical concerns in relation to CSE in Bradford beyond this particular case.

4.8. Background to the Review:

4.8.1 The journey of Autumn through services in Bradford between 2010 and 2014 has been placed in a national and local policy context, as well as being informed by relevant research findings. Bradford was one of a small number of areas who had multi-agency safeguarding procedures in place in relation to CSE in 2010. These were based on a West Yorkshire wide procedure which was agreed by all of the Local Safeguarding Children Boards in 2008. Bradford has been developing services and responding locally to CSE since 1995.

4.8.2 The identification of serious and significant concerns about Autumn's safety and welfare were a key catalyst in the Safeguarding Children Board running a Challenge Event in November 2011. This Challenge Event, along with a key change of leadership for CSE in West Yorkshire Police, and with additional leadership from the Board and Children's Specialist Services, led to the establishment of the CSE Hub in Bradford in January 2012. Among a number of concerns for the CSE Hub was a focus on the risks to Autumn.

4.8.3 In addition there has been a continuing, positive and proactive response to learning and development in leadership and Governance terms since 2012. The Police led and convened a dynamic learning review with Children's Specialist Services in August 2013. The focus of the review was to identify learning which focused on the issues arising from Autumn's case.

5. Autumn: Her lived experience and a pen picture of her journey through life as a child and youn person:

5.1 Autumn as the subject of this review and as she has developed over time:

5.1.1 Autumn was interviewed for this review in July 2015 in the presence of the manager of the residential unit she was living in at the time. As will be seen from the summary below, professionals had contact with Autumn in a number of different contexts and circumstances over time and this inevitably shaped their views and assessments of Autumn and her family. One of the key benefits of the first learning event, for practitioners who knew Autumn during her journey through services, was to understand who Autumn was and who she became before and after their contact with her.

5.2 Autumn's lived experience and journey:

- As a neglected and physically abused child.
- As a member of a family and community with a number of identity issues in relation to culture and ethnicity.
- As a learner.
- As a young person identified with problematic behaviour.
- As a victim of child sexual exploitation including multiple rapes.
- As a young person accommodated by the Local Authority living away from her home community.

In the next sections, the review will describe in more detail, her family and community context and will conclude with an overview of her vulnerability.

5.3 As a neglected and physically abused child in her family:

5.31 Autumn had a fractured experience of family life during her early childhood up to the age of 10. It appears that her birth father left the family home when she was four and that her mother remarried when Autumn was 10. Autumn reports that her experience of family life up until her father left was positive and that her mother had problems coping until she met her new partner.

5.3.2 Autumn describes not getting on with her stepfather and this being the cause of conflict in the home. Autumn gave this as the reason for moving to live with her maternal grandmother who became a source of refuge and support for her. Autumn reluctantly moved back home when her grandmother needed to care for her cousins. Autumn says she saw her father on a regular basis apart from a period of a year when her mother prevented her from seeing him.

5.3.3 Autumn experienced significant continuing enuresis problems as a child, which her family describe as having had an impact on her social development. Concern was expressed in 2003 about parental failure to bring Autumn to continence clinics. The Bradford District Care Foundation Trust (BDCFT) IAR author notes that:

'her significant continence problems remained unresolved at the age of 12 years'

The BDCFT IAR Author also goes onto state that this condition can have a significant impact on the lived experience of the child:

'Urinary incontinence can be very distressing for a child. They can lose confidence, may feel socially excluded and in some cases might be bullied. They may even find it difficult to function normally in everyday life.'

Both NICE guidance issued in 2009 and Royal College of Paediatrics and Child Health (RCPCH) Guidance, issued in 2014 indicate that secondary incontinence at this age is unusual and is suggestive of psychological causes. The guidance indicates that concerns about maltreatment may include sexual harm. The Designated Doctor for Bradford also noted:

'A typical child with bedwetting (nocturnal enuresis) is a 7-8 year old boy with primary enuresis often with a family history (dad / uncle) that had the same condition, and has no indicators for other causes (e.g. symptoms of infection, or other medical causes). Whilst there may be mild elements of stress or psychological issue which may exacerbate this they usually respond well to basic measures.'

There were concerns expressed that Autumn may have had contact with People Posing a Risk (PPR), during her childhood. These were investigated by Children's Specialist Services and no concerns about potential contact were identified.

5.3.4 There is evidence that enuresis had, and continued to have, a significant impact on Autumn's lived experience, particularly when she was stressed. Her family describe her isolation and lack of confidence in having friends home or going to stay with friends. There is evidence that Autumn was bullied and this symptom may have been a factor.

5.3.5 Autumn reports that she has three kidneys and that this was confirmed by a scan whilst she was at the residential placement. Whenever Autumn had a test recorded for possible urinary tract infection the results came back negative, so it is very unlikely that the abnormality of the kidneys resulted in the incontinence.

5.3.6 Autumn describes a relationship with her mother characterised by neglect, aggression and physical assault as well as issues with alcohol and domestic abuse. Autumn still has some anger towards her mother about her failure to consistently nurture her and protect her. Autumn says she often felt rejected and let down by her mother. Autumn did make disclosures about physical assaults by her mother to her primary school, which were ineffectively responded to following Autumn's withdrawal of the allegations. Autumn says she 'had lost faith in the systems' ability to protect her' by the age of 10.

5.4 As part of a community with a number of issues in relation to identity and culture and ethnicity:

5.41 Autumn and her local community and immediate locality:

5.4.2 Autumn grew up in the predominantly Asian part of her community, with relatively few white families living in the immediate vicinity. When she went to secondary school she became friendly with a group of Asian girls from another school. At this point Autumn seems to have embraced aspects of a Pakistani identity. She adopted Asian dress and learnt some Urdu. Autumn had Asian nicknames and created a number of Facebook accounts using Pakistani names. There is no evidence that Autumn engaged with any religious practices or became interested in the faith aspects of the Pakistani identity.

5.4.3 Autumn's home was on the outskirts of the town centre. Autumn lived halfway up a hill. At the top and bottom of the street were two gangs. Autumn was groomed and abused by both groups.

The Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups (2013) defines a gang as:

'...relatively durable, predominantly street based, social groups of children, young people and, not infrequently young adults who see themselves, and are seen by others, as affiliates of a discrete, named group who engage in a range of criminal activity and violence; identify or lay claim to territory; have some form of identifying structural feature and are in conflict with similar groups.'

A group is defined as:

'... two or more people of any age, connected through formal or informal associations or networks, including but not exclusive to, friendship groups.'

The official definition of a gang as described by the Metropolitan Police in their leaflet 'Gangs and Violence: Get the Facts' is as follows:

'A gang is usually considered to be a group of people who spend time in public places that see themselves (and are seen by others) as a noticeable group and engage in a range of criminal activity and violence. They may also lay claim over territory and be in conflict with other gangs.'

On the basis of these definitions Autumn was sexually exploited as part of gang activity in her home town. The nature and impact of this harm is described in 'It's wrong...but you get used to it' published by (Beckett et al 2013)

5.4.4 There is a strong local identity in her home town. Some people in the town take a pride in its independence from the rest of Bradford and see it as having more in common with other towns. The levels of deprivation and low levels of employment and other opportunities in her home community contributed to the development of an informal and illegal economy and a low level criminal culture.

5.4.5 Health provision covers overlapping boundaries and children and young people also attend schools in other areas. Until recently it was a separate Police Division. There is a good partnership network of key agencies working together in her home community to tackle a range of complex and challenging issues, not just CSE. There is also a lot of local interfaith working.

5.5 Autumn's home community and Child Sexual Exploitation:

5.5.1 Concerns about her home community and child sexual exploitation were raised by the Local MP and a television documentary was made about the concerns. There have been a number of media reports about her home community and the issue of CSE. There are other historical and current CSE cases in Autumn's home community which are being actively worked on. A range of proactive work about CSE is taking place to provide additional support in her home community and this is described in a later section.

5.6 Autumn's journey as a learner:

5.6.1 Autumn and her mother both reported that Autumn liked sports as a child particularly PE, Rugby and Football which her mother also played. Autumn says she enjoyed nursery and primary school. Autumn describes herself as loving learning and being naturally curious and intelligent.

5.6.2 Autumn had difficulties in coping with being in mainstream secondary schooling and these problems continued in her residential placement. Autumn re-engaged with learning following a move to a Pupil Referral Unit and enjoyed her time at another provision in Bradford. She also thrived at the specialist provision commissioned as part of her residential placement. Smaller provision seemed to suit Autumn well in terms of her ability to access the curriculum and to learn.

5.7 As a young person identified with problematic behaviour:

5.7.1 Autumn was regularly truanting in May 2010 and her first missing episode was reported by the family at this time. She was referred to Local CSE support services for support by the school in June 2010. This was also associated with an issue of enuresis at Autumn's school.

5.7.2 Autumn describes herself as withdrawing and closing off during this time – "building walls and steel wraps around myself". At the first learning event the workers who worked with Autumn at that time recognised that she was hard to engage with, appeared withdrawn and that this became a consistent pattern in her behaviour.

5.7.3 A lot of the professional concern at this point focused on Autumn's behaviour. Autumn is very appreciative of the support she received from the Pastoral Support Team at her School who went out of their way to keep her engaged and attending School. Autumn was also appreciative of the way a particular Police Officer engaged with her when she was returned home after being missing.

5.8 As a victim of child sexual exploitation, including multiple rapes:

5.8.1 The Judge in the criminal trial found that Autumn was raped and sexually assaulted between May 2011 and May 2012. Twelve men were convicted and sentenced for these offences.

5.8.2 Autumn's grooming into sexual exploitation seems to have grown out of her engagement in drug dealing. This was as a result of a relationship with a male who was the lead groomer for a gang based in Autumn's community. Having been involved with him for a while, and being used to ferry drugs around in her local community and the wider area, he raped her in early May 2011. This was the start of the sexual violence, Autumn had previously reported coercion and threats in April if she failed to do drug deals for the gang. This period coincided with a significant increase in the frequency of missing episodes.

5.8.3 Autumn's family describe not being able to protect her, being desperately worried about her being missing, and searching for her in her home community. Autumn reported that if she didn't go missing then her home and family would be targeted. Autumn reports that she felt coerced into the abuse to keep her family and sister safe.

5.8.4 Autumn's family had protective measures installed at both her mother's and grandmother's houses. They were subject to verbal abuse on the street from the individuals involved. Autumn lived in a small community and there was little opportunity for escape or respite for her during this period. Her family did send her to stay with her Aunt who lived outside of her home area during a school holiday.

5.9 As a young person accommodated by the Local Authority:

5.9.1 Autumn still feels let down that her mother 'signed me into care'. She feels angry at Children's Specialist Services and the police for not protecting her earlier and not working with her more to protect herself. Autumn describes refusing to be accommodated away from her grandmother's home when she was made subject to Police Protection. Autumn returned to her grandmother, despite being told she was not allowed to return to Keighley and was told that it was her aunt's birthday. Autumn cites the reason for leaving the first foster placement, was that she never wanted to be in care and that the carer's response to her safety showed they did not understand the risks involved.

5.9.2 After a number of missing episodes, Autumn was able to remain in her residential placement with a lot of support from the team. Autumn describes the support provided by key members of staff as instrumental in her decision to remain in her residential placement and not go missing again. Autumn recognised that she had had appropriate boundaries put in place for her and therefore, in that sense she was challenged about her behaviour. Gradually, through this process Autumn was able to make changes to her behaviour. Autumn was able to engage with multiple evidential interviews with the key workers support, although she found this very difficult. As a result of the service provided in the placement, Autumn was able to step back into education and able to flourish and succeed in unexpected ways.

5.9.3 The residential unit, the police and Children's Specialist Services were able to support regular contact with her family who were all committed to staying in contact with her. Other providers were all able to offer support to Autumn and the placement. Her contact with those exploiting her diminished and then appeared to cease. She also felt some residual anger about the perpetrators still living in her home community whilst she had to live away from her immediate family.

5.9.4 Autumn was now in a placement regarded as safe by professionals, and she experienced being nurtured, cared for and supported to develop and achieve. She was able to make the best of the experiences and support offered to her. She was also supported to access justice and to recover from her trauma. Autumn stayed in this placement until the conclusion of the criminal trial.

5.9.5 Autumn has derived a positive benefit from her contact with horses, in particular the physical activity and focus it provided. Concerns remain, that despite a number of offers, she has never really been able to talk her experiences through in a therapeutic setting to support her recovery. Based on two independent psychological assessments of Autumn, the Judge at the criminal trial acknowledged in his sentencing remarks the severe psychological harm she had suffered and the likelihood of its continuing impact into adulthood.

5.9.6 Autumn is however still very angry about the way the possible placement with her maternal aunt was handled. She is also very angry about Children's Specialist Services initiating formal proceedings prior to her 17th birthday despite having complied with all the boundaries set for her. Autumn says that the anxiety this action caused contributed significantly to her poor performance in her GCSEs. It is an indicator of her progress in the placement that having previously been passive and compliant she was able to speak to the Children's Commissioner and instruct her own solicitor to oppose the granting of the order, which she successfully did

5.10 Autumn's immediate family:

5.10.1 Autumn's mother:

5.10.i Autumn's mother was described by the CAMHs service as having an avoidant attachment with her daughter. The implications of this are discussed later in the report. Autumn's mother was not able to sustain caring for Autumn safely or reliably and there are a number of reports in the chronology of her mother drinking alcohol and both Autumn and her sister being frightened to be at home.

5.10.ii Autumn's living arrangements with her mother broke down completely at the end of October 2011 when her mother went on holiday for two weeks leaving Autumn and her sister in the care of their grandmother. Autumn had very little contact with her mother whilst she was living with her grandmother. However, Autumn's mother and stepfather attended some meetings with the school and some child in need meetings, regularly reported her missing, went looking for her and collected evidence about her missing episodes. Autumn's mother supported Autumn in her residential placement and continues to offer her support.

5.10.2 Autumn's Grandmother:

5.10.2i Autumn's grandmother has consistently cared about and supported Autumn and looked after Autumn regularly. In particular, when she was aged between 9 and 11 and from October 2011 to June 2012. However, Autumn's grandmother found it difficult to protect Autumn and could not prevent her from going missing or ensure that she attended school. This took a significant toll on Autumn's grandmother's physical and mental health. Parents Against Child Sexual Exploitation (PACE) provided Autumn's grandmother with support during this period.

5.10.2ii Autumn's Grandmother supported the Police in gathering evidence, reported her missing and attended Child in Need meetings. She went with Autumn to support sessions, encouraged her to attend the sexual health clinic and was involved in joint sessions with Autumn and CAMHs. Grandmother was actively involved in visiting and supporting Autumn in her residential placement and continues to be involved. She did give Autumn an internet enabled mobile phone in the placement, contrary to Police advice and the agreed care plan, which created some risk and vulnerability for Autumn.

5.10.3 Autumn's Father:

5.10.3i Autumn's father identified himself as dual heritage having had a Pakistani father and a white mother. Autumn's father grew up in Birmingham. He was one of eight siblings and described himself as estranged from his immediate family and isolated within the local community.

5.10.3ii He was not actively involved in her care when he left the family home. He was described as having a drinking problem and suffering with asbestosis and reported to be terminally ill in 2011 and 2012. He died in February 2015. Autumn was actively involved in the preparations for the funeral and in attending the funeral.

5.10.4 Autumn's maternal aunt:

5.10.41 Autumn's maternal aunt was considered as a carer for Autumn but was eventually assessed as not being suitable due to personal and family circumstances and history. Autumn stayed with her aunt as a respite from the abuse in her home community.

5.11 Exploring and understanding Autumn's vulnerability to child sexual exploitation:

Research and experience indicate that groomers often seek out vulnerable young people. (Barnardos 2011, Berelowitz et al 2013, DCSF 2009). Autumn had a history of difficulty and

vulnerability in her childhood. In this section we seek to draw out the key factors which led to some of her vulnerability

5.11.1 The community in which Autumn lived:

Autumn lived in a house located between two gangs, both of whom targeted Autumn for exploitation.

5.11.2 Autumn's early life:

Autumn's early life was characterised by insecure and conflicted attachments which contributed significantly to her isolation, vulnerability and lack of trust. By the age of ten she had already experienced family breakdown, physical assault and neglect. She was living as part of a reconstituted family where alcohol use was an issue. Her mother had failed to provide consistent support to resolve her incontinence issues and had physically assaulted her. At the age of ten she was reluctantly back living in her reconstituted family with her mother, stepfather and sister.

5.11.3 Other conflicted attachments and family vulnerability:

Autumn has People Posing a Risk within her immediate family and there were concerns that she had had inappropriate contact with them. Her father left her mother when she was quite young and she subsequently had sporadic contact with him. Her relationship with her step-father was difficult and she left the family home to live with her Grandmother. These factors resulted in Autumn lacking consistent care and warmth at home, and to her often choosing not to be at home. Her groomers in contrast offered her what is often described as an alternative 'destructive consistency'.

5.11.4 The response of services to previous allegations:

Autumn alleged harm from her mother on three separate occasions. She also made an allegation of rape by her main groomer. Whilst Children's Specialist Services did respond to these allegations, Autumn withdrew or denied them at interview. As a result no further action was taken to protect her following these disclosures. Autumn lost trust in the system there to protect her and the system in turn began to see her as problematic:

"A perception that a young person is troublesome, rather than troubled, can affect their credibility and influence whether that individual seeks help. It can also make them fiercely resistant of offers of support. Rejecting help is more likely if the young person feels that they have been let down in the past by those who should have been protecting them."

- The London CSE Operating Protocol, March 2015, Metropolitan Police.

5.11.5 Autumn's isolation:

5.11.51 One of the consequences of Autumn's relationship with her mother was the development of a pseudo independence resulting from the avoidant attachment her mother had with her. Autumn's dual heritage may have caused some additional vulnerability as she explored her identity. Her longstanding enuresis caused some isolation from her peer group and this isolation was commented on by professionals. Threats to Autumn's family and sister were used by groomers as a means of controlling her and further increased her isolation.

6. Key periods and events identified on the timeline and within the integrated chronology:

6.1 Prior to 1st January 2010:

6.1.1 Initial contact:

The first recorded contact with Autumn and her family was by the School Nurse in February 2003, when Autumn was five years old. This was an entry in the School Health review identifying day and night time urinary incontinence as an on-going issue. A referral to incontinence services was made the same day and followed up with the GP and safeguarding nurse.

6.1.2 A failure to successfully address Autumn's enuresis:

It was recorded that Autumn was not brought by her mother to the appointment made for 3rd. June 2010 and there are further episodes prior to this. It is also recorded that concerns were expressed to Children's Specialist Services, by a Doctor, about this in 2006. Despite regular expressions of concern raised by the school and the school nursing service about Autumn's enuresis by 2010*, "her significant problems remain unresolved at the age of 12"* (BDCFT IAR Report). There is evidence of one short term piece of work taking place between school nursing and the school, but no common assessment (CAF) was completed. There is no evidence that the incontinence was considered in relation to any safeguarding or psychological concern at this time.

6.1.3 Three specific allegations of physical assault by mother on Autumn

6.1.3i Autumn talked to her primary School on three separate occasions about experiencing physical assaults by her mother. These were in the February 2005, 11th January 2006 and on the 15th November 2007. It has not been possible to access these records from her primary school at this time and these records, along with the concerns about enuresis were not passed on to the secondary school.

6.1.3ii On the 15th February 2005, Autumn alleged assault by her mother with a training shoe. This was followed up by Children's Specialist Services who recorded that Autumn then withdrew the allegations and that advice was given to mother. Autumn was not seen by a Doctor in relation to this incident.

6.1.3iii On the 11th January 2006, school nursing recorded a conversation with Children's Specialist Services that Autumn had disclosed to the school that she had been hit and threatened with a knife or rolling pin and they also identified continuing concerns about urinary incontinence. Following a visit by Children's Specialist Services they recorded that Autumn again withdrew the allegations and mother said it hadn't happened. As before, further advice was given and the case closed.

6.1.3iv On the 15th November 2007, Autumn told her school that her mother hit her and her sister on a regular basis. This time an initial assessment was undertaken by Children's Specialist Services. The assessment identified the 2005 incident, the concern expressed by the Doctor in 2006 and also uncovered contact with Children's Specialist Services in 2002. The 2002 referral related to unsubstantiated concerns about unsupervised access to People Posing a Risk to Children – mother's step sister and son. Autumn's mother was assessed to have acted appropriately in relation to the People Posing a Risk. At this point it was also recorded that Autumn's father had left the house and that a new partner had moved into the house. Mother was seen again by Children's Specialist Services on the 29th November 2007. At this interview mother said that she did smack Autumn as she had bitten her sister but denied that she had used an implement. She repeated that she had smacked Autumn. She is recorded as saying that she was sorry and

that she loved her children. On the 21st December 2007 a manager decided that there would be no further action. This time period coincides with Autumn leaving the family home to live with Grandmother for the first time and these incidents may have been part of that decision.

6.2 Key events during 2010:

6.2.1 <u>March 2010: Episode of urinary incontinence in School, first missing episode and contact with the GP about soiling and hiding food:</u>

6.2.2 On the 15th March 2010, there was an episode of Autumn experiencing incontinence at her secondary school. During the school's follow up the next day, Autumn said that she was unhappy at home and that she wanted to go and live with her grandmother. Autumn said that she was falling out with her mother and that her step father only had time for his children. Autumn also said she was getting into trouble and didn't know why. The school referred Autumn to their school counsellor and she was positive about the support she received from them. Autumn saw this person regularly until she went to the Pupil Referral Unit.

6.2.3 The first missing report to the police was made on the 16th March by Autumn's mother. Autumn failed to return home after attending sea cadets. She eventually returned to her great grandmother's address at around 11pm. On the 17th March, Autumn and her mother attended a GP appointment. Autumn's mother told the GP that Autumn was faecal soiling and stealing food and that Autumn wouldn't talk to her. The GP made a referral to a joint CAMHs and School Nurse support clinic. The aim of the clinic was to carry out a holistic assessment of Autumn and the family. The outcome of the assessment would determine whether a package of care to address the identified need could be delivered through the clinic. If not, the assessment would identify whether a referral to a more specialist service was required. Autumn and her mother did not attend the appointment made for the 3rd June 2010. On the 24th March, Autumn had the first of a number of tests for urinary tract infections which were all negative.

6.2.4 <u>6th and 7th June 2010: Further missing episodes:</u>

6.2.5 Autumn's mother reported her missing to the Police just before midnight on the 6th.June. Autumn had failed to arrive back home in a taxi following a visit to her father. Autumn was found in the town centre at about 10:00am the following day and Police conducted a return interview. Autumn's mother is recorded as saying, during the return interview, that there were problems at home and at school. She explained that she had been into school to discuss these problems. She added that Autumn had some older male friends who were Asian and not many friends her own age.

6.2.6 Autumn was also spoken to for the return interview and stated she had gone missing to get space from her mother and that she was not settled at her mother's house. Autumn said she had previously lived at her grandmothers. The Police Missing Person (misper) report also mentioned Autumn as being a victim or potential suspect of bullying at school. As a result of this incident the Misper Coordinator for West Yorkshire Police referred Autumn to the Barnardos Turnaround project and gave an update to the school. This was in line with the procedures and processes for dealing with these concerns at this point in Bradford. There is no record on the school's chronology that this referral was received.

6.2.7 <u>8th July 2010: Response from Barnardos Turnaround service:</u>

6.2.8 Despite receiving the Misper referral on Monday the 8th June, the service did not respond until the 8th July. A Senior Practitioner arranged to visit the family on the 13th July 2010. Autumn's mother was seen by the Senior Practitioner at this home visit, but not Autumn. The assessment of Autumn is recorded in the Barnardos chronology. The assessment concluded that

Autumn was at high risk of Child Sexual Exploitation as a 12 year old who had been missing on two occasions, and who had also received texts and phone calls from much older, unknown men. The assessment also recorded a concern that Autumn was not acknowledging the risk. It is recorded that the high risk assessment of CSE was agreed with Autumn's mother. An agreement was made to refer Autumn to a local support service, which unlike Barnardos provided a CSE support service in the part of the District where Autumn and her family lived. The case was closed by Barnardos on the 9th August. **This is a pivotal point 1 (see p.43)**

6.2.9 The local CSE support service received the referral from Turnaround on the 15th July and it is recorded that the referral included the receipt of inappropriate text messages from a 30 year old male. The support service checked with Children's Specialist Services who were recorded as saying the case was closed in 2007. The support service spoke to mother on the 27th July who is recorded as saying that the situation was calmer, that Autumn now had support once a week at School and that she had some new friends. Autumn was invited to attend a group over the summer but she didn't go.

6.2.10 Phone calls were recorded as having been made to mother but with no response. A telephone call to the Police Public Protection Unit was recorded on the 3rd August where the local CSE support service recorded being told that Autumn had friends in school who were older boys and that there were no CSE concerns. An action was recorded following this for the support worker to make contact with school in September. The local CSE support service made contact with the school on the 12th October and no reason was recorded for the delay. Autumn's school reported no CSE concerns but felt she was quite vulnerable.

6.2.11 <u>Disclosure of sexual abuse concerns about Autumn by her sister at School:</u>

6.2.12 Children's Specialist Services received a referral from Autumn's sister's primary school on the 9th November 2010. The referral explained that Autumn's sister had told them that she was worried that Autumn might be at risk of sexual abuse. This was in relation to their mother's step brother, a person recorded as posing a risk to children (PPRC), about whom concerns had originally been assessed in November 2007. Children's Specialist Services received further information from Autumn's mother and her school on the 18th November (which coincided with Autumn's absence from school).

6.2.13 On the basis of this further information a referral was accepted and it was agreed that an initial assessment would take place. The purpose was recorded as to inquire further into Autumn and her sister's contact with the Person Posing a Risk to children. This contact was recorded as taking place outside of School with Autumn's sister at her father's home. As a result of a visit to mother on the 24th November a decision was made to progress this from an initial to a more detailed core assessment.

6.2.14 On the 15th December both sisters and mother were seen as part of the core assessment. Both sisters were spoken to about their contact with the people previously identified as Posing a Risk. The core assessment was completed on the 4th January 2011 and a decision was made to close the case. Primary school checks are recorded in the chronology to have revealed no concerns. In the assessment both girls are described as being 'friendly and confident young people with a close and loving relationship with their mother, who says that they are well behaved and there are no issues with either of the girls'. The contact with the Person Posing a Risk was found to be unsubstantiated and mother was seen as protective. The previous concerns around physical abuse and enuresis were mentioned but not included in the analysis. **The consequences of this assessment are pivotal incident 2.- in the progression of Autumn's journey (see p.43)**

6.3 January to June 2011:

6.3.1 <u>January to March 2011</u>

6.3.1 By January 2011, Autumn's school attendance was at 85% and on the 27th January she was selected for an attendance challenge programme. Autumn then came to the attention on the 17th March 2011 when there were a series of truanting episodes from the 17th March to the 1st April.

6.3.2 <u>8th- 13th April 2011</u>

6.3.3 On the 8th April Autumn's mother informed the school that she was again arranging for Autumn to stay with her aunt at Easter. She was concerned that Autumn was lying to her and spending time with 'Asian kids'. She had also arranged for Autumn to stay away from home at the weekend. Autumn went missing on the 9th April and the police record reports that Autumn's mother was concerned that Autumn was being groomed by local Asian males and was vulnerable to sexual exploitation. The police reported no concerns about CSE in their report. Autumn went missing again on the 11th April and on the 12th April. Autumn's grandmother reported concerns that Autumn was associating with older males. The police recorded that she was easily led but not necessarily vulnerable to sexual exploitation.

6.3.4 On the 13th April when Autumn was returned home following another missing episode, she provided a lot of additional information at her return interview. Autumn alleged that her mother hit her when drunk. She stated that she didn't get on with her mother and stepfather, that they drank alcohol, and that her mother lost control and hit her. She also said her mother had called her a 'Paki shagger'. The record noted that Autumn smelt strongly of urine during the return interview and said she was being bullied at school. Mother said that Autumn had three kidneys and suffered repeatedly from urine infections.

6.3.5 Autumn's school reported that Autumn's mother contacted them about this incident and that she had found texts and numbers from Asian males and an email address for Autumn in the name of Hussain. The school re-referred Autumn to the local CSE support service via a personal email address. The police also recorded that Autumn's grandmother had care of Autumn's two cousins at this time. Consequently, Autumn may not have been able to take herself out of the tensions in the family home and go to her grandmother's as an alternative to being missing. The police IAR authors also state that at this point, Autumn disclosed to her family that she was under pressure from white males to do drug deals or they would smash the family's windows.

6.3.6 <u>14th April 2011: Children's Specialist Services Initial Assessment</u>:

6.3.7 Autumn went missing again on the 16th April. An initial visit took place in response to the identified concerns and a decision to undertake a further initial assessment decision was confirmed by a manager on the 18th April. An allocated social worker visited the family on the 20th April when Autumn was staying with her Aunt in the south of England.

6.3.8 The language of this assessment framed the concerns around Autumn's behaviour and actions rather than focusing on what might be happening to her. She was described as 'continuing to place herself at risk' and as associating with older Asian males, rather than adults abusing her vulnerability and placing her at risk. There was a description of her getting involved in adult type sexual behaviour rather than being sexually abused. The assessment concluded that her self-esteem and need for attention was what was causing her to place herself at risk.

6.3.9 Autumn was described as presenting as very vulnerable at interview. Once again when asked, Autumn withdrew the issues and concerns she raised about her mother and said there was no

longer a problem. She also revealed that she had been living with her maternal grandmother for a year and that she had little contact with her father due to his issues with alcohol. Autumn also said that she had a good relationship with her stepfather.

6.3.10 The assessment recognised that Autumn's mother found herself unable to keep Autumn safe and that she had tried a number of strategies to achieve this. Autumn's mother requested additional support from Children's Specialist Services and her school. At this point the school nurse records faecal soiling as a concern, but this was not mentioned in the initial assessment completed by Children's Specialist Services.. Autumn's school expressed concerns about her attendance which had now dropped to 80%. They also expressed concern about her risk of CSE and that she may have been 'got'. The school had at this point referred Autumn to the Education Social Work team for attendance issues and, as previously indicated to the local CSE service for support.

6.3.11 The Children's Specialist Services IAR author expressed concern that the initial assessment took a month to complete and that a decision to progress to a core assessment was made but not progressed. The IAR author further stated, that at this point sufficient information and knowledge existed about Autumn's vulnerability and risk to justify a strategy discussion to actively and formally consider the safeguarding concerns. The actual outcome of the assessment was to offer support to Autumn and her family. **This is identified as a pivotal incident 3 (see p.44).**

6.3.12 <u>Autumn's rape on the 3rd/4th May 2011</u>

6.3.13 Autumn's school reported on the 3rd May that her mother had told them that Autumn had had a good holiday with her aunt and had been 'really good' since her return. It was agreed that Autumn would return to her school the following day as part of a meeting at 11:15. On the morning of the 4th of May Autumn's mother rang the school to say that Autumn would not be attending school. Autumn's mother explained that Autumn had gone missing the previous night and said she had been raped. Autumn's mother told school that she was not sure about rape. The school is not recorded as having done anything with this information. Autumn was 13 years old at this point.

6.3.14 Autumn went with her mother to see the GP on the 4th May and again Autumn said she had been raped. The GP's recorded response was to provide contraception and give literature. No further action is recorded as having taken place.

6.3.15 The rape was reported to the police on the 4th May and the police seized clothing and underwear and interviewed Autumn. Autumn said she had been driven around and raped by masked offenders. Autumn said that her clothing had already been washed and that she had had a bath prior to the Police arriving. Autumn was described by the police as refusing to be medically examined and as retracting her allegation. The incident was categorised as a false report by the police as there was no supporting evidence from any source. Autumn states that she was willing to have a medical examination but was never asked. The police informed Children's Specialist Services about the rape on the 27th May 2011. ***This is a pivotal incident 4 (p.44).***

6.3.16 <u>May 2011</u>

6.3.17 In the early part of May Autumn attended school erratically and arrived late but didn't go missing. The local CSE support service responded to her school to say that Autumn had been put on a waiting list. On the 18th May Autumn reported to her school that she had fallen out with her mother that morning and that she had pinned her up against the wall. Autumn also reported that she didn't like being at home and felt that her mother only had time for her stepfather and sister. This is not recorded as being passed on to anyone else.

6.3.18 On the 22nd May, Autumn went missing and a text was found which linked her to seeing a known male at 4am in the morning. The police attended her school in an attempt to locate Autumn the following day. On the 24th May there was a meeting in Autumn's school to co-ordinate information and evidence. It is not recorded whether this material was passed onto any other professional. The school also received information on the 25th May about Autumn being in contact with someone known to be involved in grooming. Again, it does not appear that this was passed on. On the 25th May Children's Specialist Services allocated a Community Resource Worker (CRW) to Autumn's case with a clear plan of action focused on Autumn. A Community Resource Worker is not a qualified Social Worker.

6.3.19 On the 27th May the police shared the information about the rape with Children's Specialist Services, together with information that Autumn was associating with peers and adults associated with CSE. A decision was made, following this information, to hold a CSE strategy meeting on the 8th June. A CSE strategy meeting did not form part of the child protection process and was not the same as a S47 strategy meeting. The CSE strategy meeting was a process within the CSE framework to determine the level of risk of CSE a child might be experiencing. A S47 strategy meeting forms part of the child protection process and is held to consider whether a child is suffering significant harm and a section 47 investigation is required. This differentiation was not considered by the police or Children's Specialist Services and this resulted in a further delay in the risks to Autumn being assessed. As the Children's Specialist Services IAR states:

'information is treated as intelligence and is treated discretely and separated from assessment and decision making processes'.

6.3.20 The CRW visited the family on the 31st May when it was clear that Autumn's family were struggling to cope with the situation at this time. The visit is recorded as addressing 'a number of surface issues'. The chronology records that in supervision Autumn is identified as having made false accusations when scared of punishment at home. The Community Resource Worker made two more failed attempts to see Autumn prior to the strategy meeting.

6.4 June to July 2011:

6.4.1 <u>The CSE Strategy meeting on the 8th June</u>

6.4.2 Minutes of the meeting indicate that the CSE strategy discussion failed to pull together key information pertinent to Autumn's welfare and safety. Autumn's school did not share significant information recorded in the chronology and the school nurse provided no context around Autumn's history of enuresis and incidents of soiling. Previous incidents of physical abuse and Autumn's unhappiness at home were not included and the local CSE support service did not provide information about the previous referral in 2010. The Police stated that there was very little information and that Autumn was known to lie to the Police. The key outcomes from the strategy meeting on the 8th June were as follows:

- School Nurse to monitor health needs.
- Police to develop a Misper report strategy with the family.
- Parents to keep a diary of events.
- The local CSE support service to engage with Autumn and look at risk.
- The Community Resource Worker to engage father in the work. Counselling support for Autumn to continue at school. The CSE strategy meeting *is pivotal incident 5 (see p.45)*

6.4.3 <u>June and July 2011: From CSE strategy meeting to Child in Need:</u>

6.4.4 <u>*Increased co-ordination and communication during this period*</u>

6.4.5 There was increased communication between Autumn and her family, her school, the police, Children's Specialist Services and Local CSE support service during this time. The local CSE support service and the CRW each saw Autumn twice. The CRW also saw the family and Autumn's father. Autumn's mother kept a record of Autumn's missing events and communicated these to West Yorkshire Police.

6.4.6 <u>A better picture of Autumn's vulnerability and increased stress in the family</u>

6.4.7 Autumn's school attendance dropped to 75% despite the school picking her up from home in the morning. Autumn continued to describe being unhappy at home to both the local CSE support service and the Community Resource Worker. Autumn's mother reported that Autumn was wetting the bed again. Autumn was described as being aggressive to her sister during this time. Autumn's missing episodes increased putting stress on her and her family. Autumn's mother said she did not report every missing episode. Autumn was seen in places with older Asian males and mother had intelligence on these. Autumn's mother also reported the telephone ringing constantly at night when she took it from Autumn.

6.4.8 The police response to missing reports during this time was often inappropriate. Episodes were recorded as temporary absences and Misper reports were not completed. It is recorded in the police notes at this time that Autumn reported a false allegation of rape in May and wasted police time.

6.4.9 Autumn began opening up to her mother. She disclosed that something was happening to her but that she couldn't say what. The family reported that Autumn said the house might be firebombed and that she had to do things otherwise her family would be hurt. Mother and stepfather reported feeling unable to cope.

6.4.10 <u>Key events during the week of 11th to the 15th July 2011: A significant escalation</u>

6.4.11 On the 11th July the local CSE support service worker expressed concern to Autumn that she may be involved in drugs or CSE. Autumn said she would think about this. In a later telephone call to Autumn's mother, the worker also recorded that her mother had asked Autumn whether something had happened in relation to sex and drugs and Autumn said she 'couldn't say'.

6.4.12 There is also a school record dated the 11th July that stated that on Saturday 9th July Autumn was crying in the bus station. Her mother felt that Autumn wanted to tell her what was happening but Autumn said that 'things couldn't be sorted out'.

6.4.13 On the 12th July the community resource worker visited the family home. Autumn's mother talked about Autumn admitting to being involved in something and she described the concerns over the weekend. They also discussed the increased stress in the family, including the threats to the family home and family members which Autumn had disclosed to her mother the previous night. Autumn's mother talked about the possibility of Autumn staying with her maternal aunt over the summer. The CRW agreed to make a referral to placement support so that Autumn could access overnight care and the family could have some respite. Autumn's mother had gathered a range of intelligence including car numbers and details from Autumn's phone which she gave to the CRW who passed the details onto the police.

6.4.14 The CRW also visited Autumn's father on the same day and was told about his concerns for Autumn. He said that she was frightened of going home. Her father also said that he felt that she was being groomed by Pakistanis and that she had been locked in a garage, got out and came to his house.

6.4.15 On the 13th July Autumn's school and the police recorded an incident with Autumn alleging that she had been 'roughed up' by an Asian man. Her school recorded buttons missing on her shirt and finger/hand marks where she had been grabbed. There is no record that Autumn was medically examined in relation to these injuries. Autumn was then recorded as saying to her mother that she was involved in something which she can't get out of and that she has to go and meet these people otherwise they will harm her family.

6.4.16 There was a collective failure to respond appropriately to the allegations of the 13th.July, and recorded Autumn's mother as saying that Autumn was involved in 'dodgy things' and that there were threats to the family and home. Autumn's mother also shared her concern that Autumn was under the influence of drugs.

6.4.17 On the 14th July Autumn's school recorded that Autumn had been missing the previous night and that this had been reported to the police. Autumn told her school that she had been driven around Bradford dealing drugs with an Asian man whom the police confirmed that they knew. This information was confirmed to the local CSE support service on the 15th July by her mother.

6.4.18 <u>The Child in Need meeting held on the 21st July 2011</u>

6.4.19 This meeting was attended by Autumn's mother, stepfather, the school nurse, two learning mentors from the school and the Local CSE support service project worker, along with the CRW and the placement support worker from Children's Specialist Services. The police gave apologies. The meeting was chaired by the community resource worker. The school nurse recorded this as a CSE strategy meeting as did the Local CSE support service and the police. The placement support worker for Children's Specialist Services recorded that they had attended a safeguarding meeting. The school recorded this as a CSE/Child in Need meeting.

6.4.20 The meeting received additional information that Autumn had broken her sister's nose. The school were sufficiently concerned about the external threats to Autumn to have stopped picking her up in their own car. Plans were made to offer support to Autumn and her family over the summer from the placement support service. Despite the events described, the level of CSE risk to Autumn was recorded as low by the meeting. The Placement Support Worker recorded the risk as high separately in the chronology. There is no evidence of a CSE assessment protocol being used to reach either of these judgments.

6.4.21 This meeting failed to put a child protection frame around these issues and to undertake an appropriate assessment. It is also an example of a range of other patterns and concerns discussed in the analysis in section five.

6.5 **From July 21st to 13th September 2011:**

6.5.1 <u>Support for Autumn:</u>

6.5.2 The original local CSE support service worker left over the summer. It was agreed that the new worker would not make contact with Autumn until after the respite work with ACReS (The placement support service) finished at the end of September. This respite work had been agreed at the Child in Need meeting as a support to Autumn and her family over the summer. The placement support work took place over the allotted period and there was contact with Autumn on 15 occasions over this time. This represented the most consistent support provided to Autumn whilst in her home community. Autumn reports that whilst she didn't go missing whilst with the placement support service she did not enjoy going..

6.5.3 Missing episodes: General pattern.

6.5.4 The police recorded Autumn's mothers' concerns about grooming, following a missing episode on the 28th July and they recorded Autumn as being at medium risk. There was a further escalation on the 2nd August when Autumn went missing until the evening. A review of the missing strategy on the 2nd August 2011 by the Misper co-ordinator decided that Autumn should have a Persistent Missing Person flag on the Police National Computer.

6.5.5 Key event: Week end 23rd and 24th July 2011

6.5.6 Autumn's mother and stepfather went away for the weekend and Autumn went missing from her grandmother's home with her cousin on both the Saturday and Sunday night. The police found Autumn and her cousin at a garage and her cousin said that Autumn had threatened to hit her if she didn't go with her. She also said that three Asian males had asked them for oral sex but they had refused. This is the first recorded instance of Autumn coercing someone else to go missing with her. This needs to be understood within the context of the duress Autumn was suffering - as explained:

"the coercion of peers is argued to be forced or learnt behaviour" (Firmin 2013)

6.5.7 This was also the third time that a garage had come up in the chronology over the summer. This incident resulted in a Harbourers Warning being issued to a security guard at the garage in the presence of the owner. Autumn had previously recorded in texts found by her mother about meeting a security guard at a centre. This incident was not reported to Children's Specialist Services by the police until the 17th August 2011. On Monday 25th July Autumn's mother reported to the placement support worker that there had been lots of cars drawing up outside the house and that she was afraid of what might happen.

6.5.8 Key event: Weekend missing episode from 19th to 22nd August 2011

6.5.9 Autumn went missing from 7:00pm on Friday 19th August to 4:00am on Monday 22nd August. Autumn's status as missing was not confirmed by the police until the Sunday night. Prior to this she was categorised as temporarily absent. The missing incident followed her mother taking her phone from her and not allowing her access to Facebook. Autumn left her sister in a public toilet when she went missing. During her return interview she was observed to be dirty and untidy and appeared to have carpet burns and abrasions to her elbows. There is no record that Autumn was seen by a doctor in relation to these injuries. She did not disclose why she had gone missing or where she had been.

6.5.10 Information from two females who had been with her indicated that Autumn had obtained keys to a vacant property. Autumn said that she had not washed or eaten for three days and that she didn't 'particularly like' what happened when she went missing. At this point the police officer is recorded to have told her that she might be taken into Police Protection or removed from home if she continues to be at risk.

6.5.11 The community resource worker visited at 10:30 on the Monday morning. At this point the CRW had clear information provided by two other girls about their whereabouts and the other concerns detailed by the police. There is no further inquiry or assessment recorded about these incidents, or any evidence of any management discussion about these significant events. In fact the CRW focused during the visit on an issue which arose with Autumn's sister sharing a bed with her father when she stayed. There was no recorded consideration of the issues with Autumn over the weekend. It is clear that at this point the CRW was out of their depth and dealing with these issues without recourse to sufficient management oversight.

6.5.12 The Child in Need/CSE Review held 13th September 2011 recorded 6 missing episodes over this period. Thirteen episodes were recorded in the chronology over the same period of time.

6.5.13 Only the CRW, Autumn's mother, a new school nurse and a new learning mentor attended this meeting. The police did not attend and nor did the local CSE support service. The police had not attended any meetings in relation to Autumn at this point. The placement support worker whose service had a lot of contact with Autumn over the summer did not attend either.

6.5.14 The review painted a falsely positive assessment of the summer which appeared to describe a more settled time at home. The Harbourers Warning was not mentioned and the weekend missing episode was glossed over. The absence of any police presence and the lack of any management oversight of the case at this point by Children's Specialist Services are significant factors in the failure of this meeting to fully assess and understand the nature and level of risk to Autumn at this time.

6.5.15 The meeting concluded that the evidence of risk of CSE was low, a finding which is clearly contradicted by the evidence in the chronology. Autumn's school attendance was now also at 62.5% and she was reported as experiencing bullying, which was likely to make her less confident about going to school. There is no recorded involvement from education social work at this point.

6.5.16 Confusion remained about the status of this meeting. The school nurse referred to this as a core group meeting and the school referred to it as a Child in Need meeting with the police calling it a CSE strategy meeting. At this point the school, police and school nursing staff all seem to assume that the CRW is in fact a qualified social worker (QSW). They do not appear to have been directly told that this is not the case nor do they appear to have asked.

6.6 From the 13th September to the 2nd November 2011:

6.6.1 September 2011

6.6.2 During this period Autumn was not at school and was missing for two weekends from the 24th to the 28th September and from the 29th September to the 1st October. The police are noted as refusing to log some episodes as missing. The school had an internal meeting and requested a referral to CAMHS by Children's Specialist Services because of concerns about Autumn lying. In the record this is agreed to but was not followed through. Autumn was also reported as taking other children with her when she went missing.

6.6.3 Autumn's mother and stepfather were reported to be at breaking point with Autumn's continuing missing episodes. The family felt that things were out of control and that Autumn wasn't safe. A suggestion was made at this point by the local CSE support service to refer the family to CROP, a support organisation for families with children and young people at risk of or involved with CSE, but this did not happen.

6.6.4 Key event: Location of a condom in Autumn's coat 28th September 2011:

6.6.5 Autumn's school found a used condom in Autumn's coat. This was reported to the police. The police advised that as no crime had been committed the condom could be disposed of. This incident is commented on later in the analysis in relation to the incorrectness of the advice given and the lack of curiosity and challenge to this advice from the school.

6.6.6 Supervision of CRW by Manager 3rd October

6.6.7 There was no apparent discussion of the escalating situation and risk to Autumn in relation to the lengths of missing episodes, the discovery of a condom and the links to adults and young people associated with CSE. Concerns were expressed about Autumn's mother and stepdad's intention to go on holiday without the children and a supportive approach was recommended in relation to continuing the CSE meetings.

6.6.8 Harbourers Warning 3rd October 2011

6.6.9 A second Harbourers Warning was issued by the police to an adult male who was found with Autumn when she was missing. This was not recorded appropriately on the police system.

6.6.10 Meeting of Behaviour and Attendance Collaborative (BAC) 6th October 2011

6.6.11 This meeting outlined concerns that Autumn was being groomed and also noted that Local CSE support service were now involved in providing support. A referral to the Education Social Work (ESW) service was agreed and accepted on the 7th October 2011. The ESW discovered that no referral had been made to Education Psychology despite a record in the minutes that it had.

6.6.12 Mother and stepfather's holiday 14th- 28th October 2011

6.6.13 This coincided with a collapse in Autumn's attendance and repeated episodes of going missing whilst she was in the care of her grandmother. These episodes appear not to have been reported to the police.

6.6.14 Escalation of concerns 28th October to 1st November 2011

6.6.15 A first session with local CSE support service took place on the 28th October, several months after the original re referral in the summer. Autumn agreed in this session that she would like to explore issues of CSE.

6.6.16 Autumn went missing on the 30th October from her grandmother's home. Both Autumn's grandmother and uncle were present during her return interview. A lengthy interview took place about previous occasions when she has been made to do things she didn't want to do and that 'they' had control over her. Autumn was upset by this but didn't disclose anything further.

6.6.17 On the 1st November the police Misper co-ordinator raised concerns that Autumn was at risk. It was agreed that this would be referred to Children's Specialist Services by a Chief Inspector. During a conversation with the community resource worker on the 1st November, Autumn's mother is recorded as having concerns about Autumn assaulting her sister – beating her black and blue. Nothing is recorded as having been done about these allegations.

6.6.18 The Child in Need/CSE meeting held on the 2nd November 2011

6.6.19 Autumn had now been missing every day since her mother returned from her holiday. Autumn's mother didn't attend the meeting. The police attended this meeting for the first time. The local CSE support service was at this meeting along with two representatives from the school. Concerns were expressed about Autumn's attendance and her going missing with other vulnerable young people. Autumn's school reported that they were actively considering a managed move at this time. Police felt that the concerns to Autumn were so great that she should now be removed from the family and placed in secure accommodation. The risk level was still assessed as medium at this time with a view that monitoring would continue through six weekly meetings. The CRW agreed to speak to her manager for direction.

6.7 **November and December 2011: Significant changes in Autumn's life:**

6.7.1 Supervision of the CRW on the 3rd November 2011

6.7.2 The significant deterioration in Autumn's home circumstances and School attendance, which was now at 42%, was discussed and it was agreed that Autumn's situation would be escalated up to Senior Managers. A strategy was developed to support Autumn by enabling and supporting her to live more permanently with her grandmother. The difficulties of achieving this in relation to the CSE issues were acknowledged. It was agreed that Autumn's grandmother was likely to need a range of support, and that the situation might be stabilised using this approach. It was further agreed that a core assessment and chronology would be undertaken to enable the pattern of Autumn's behaviour to be seen more clearly.

6.7.3 Conversation between Police and Children's Specialist Services 3rd November 2011

6.7.4 The Vulnerable Victims' Co-Ordinator (VVC) in the police spoke to Children's Specialist Services expecting a case conference to be called to discuss what more could be done for Autumn. The VVC expressed the view that Autumn required an alternative placement away from home. It is recorded that Children's Specialist Services did not agree with this. There is no record of a case conference or any other meeting taking place to discuss these concerns or the provision of any further co-ordinated care and support.

6.7.5 Meeting of the Behaviour and Attendance Collective (BAC) on the 3rd November 2011

6.7.6 Autumn's particular circumstances were discussed at this meeting along with a more general discussion about a number of young people at a similar critical level of risk of CSE. An initial decision was made to explore the possibility of a placement for Autumn at a Pupil Referral Unit (PRU) which 'might provide her with a smaller Education setting'. It was thought that this would provide a safer and more focused environment for Autumn.

6.7.7 Completion of a CSE risk assessment by the local CSE support service 4th November 2011

6.7.8 This assessment was completed using the Bradford Safeguarding Children Board's 'Assessment Tool for Professionals Safeguarding Children and Young People from Child Sexual Exploitation'. The assessment concluded that Autumn was at a high risk of CSE. The Children's Society IAR Author notes that' there is no evidence on file that this was reported to Children's Specialist Services'. This assessment was not shared at the Child in Need review on the 15th December 2011.

6.7.9 Autumn moving to live with her grandmother on the 4th November 2011

6.7.10 Autumn's mother made a decision that she could not continue to care for her daughter and Autumn moved in to live with her grandmother full time. The placement with Autumn's grandmother did not result in Autumn increasing her attendance at school nor did it stop her from going missing. **This is a pivotal incident 6 (see p.46)**

6.7.11 Autumn's disclosure, violence and threats to her Uncle 6th November 2011

6.7.12 The police recorded that Autumn's uncle had contacted them to say that Autumn had told them that she had been hit by a male and that this male kept wanting her to meet him late at night. Autumn said she was scared of this male and the uncle felt that this was why she was going missing. There is no recorded follow up to her uncle or Autumn in response to this information.

6.7.13 Discussion of Autumn at Safeguarding Children's Board Challenge meeting 8th November 2011

6.7.14 The placement support worker recorded that Autumn's case had been anonymously discussed at this meeting and that Autumn was in the top ten young people at risk of CSE in Bradford District. It was not recorded as to what being in the top ten meant. It would appear that this information was not passed on to the community resource worker and no mention of this is made in the Child in Need meeting held on the 15th December 2011 However, it was clear that from this point on, Autumn's situation had a high profile with the Safeguarding Children Board. It also resulted in senior leaders in key agencies reconsidering and reframing their approach to CSE in the District and eventually creating the initial CSE Hub in January 2012..

6.7.15 Pregnancy concerns: Visit to the GP 10th November 2011:

6.7.16 Autumn's grandmother took Autumn to the GP on the 10th November and discussed a range of concerns in relation to Autumn including staying out late, being groomed and being brought back by the Police. The GP saw Autumn alone and Autumn reassured her that she was not pregnant and that she was not doing things against her will and that she had a support worker.

6.7.17 The GP followed up this consultation by contacting the support worker on the 17th November 2011. This contact is recorded on the chronology by the GP but not by any other agency. The General Practice IAR report states that this was the placement support worker but this is not clear from either the chronology or the IAR. The recorded contact in the chronology states that 'Social Services' were aware of the situation and were supporting Autumn and her mother and grandmother. The GP said she would be happy to see Autumn again to discuss contraception.

6.7.18 The GP practice was not formally told about CSE concerns in relation to Autumn until a letter was received from CAMHs in April 2012. There were a number of other records of concern in relation to Autumn's potential pregnancy. No other action was taken about this and this was not mentioned during the Child in Need meeting on the 15th December 2012.

6.7.19 Concerns identified in relation to Autumn on the 10th and 11th November 2011

6.7.20 The placement support worker saw Autumn on the 10th November and recorded being very concerned about her behaviour in the car. Autumn was described as shouting to males on the street and trying to attract their attention. The community resource worker recorded on a visit to Autumn's grandmother's home that Autumn's uncle told her that a 'named key accused' was the person who was assaulting Autumn, causing her to be scared and going missing. He also said that Autumn was not specific about what happened but she did say that what happened was illegal. The uncle also alleged that Autumn's mother and stepfather regularly drank and that her stepfather had hit Autumn's mother on occasion.

6.7.21 Autumn's uncle was recorded as repeating these concerns to the police on the 11th November. They also recorded that Children's Specialist Services were made aware. The community resource worker spoke to Autumn about her uncle's concerns and Autumn is recorded as denying having opened up to her Uncle. There is no record of any action to follow up this information. The CRW does not appear to have discussed this information with her manager and the police took no further action. This information does not appear to have been discussed at the Child in Need meeting on the 15th December.

6.7.22 Engaging with other services

6.7.23 The CRW had a consultation with CAMHS on the 16th November with a view to them becoming involved. They responded on the 24th November stating that Autumn was too chaotic to be considered for' one to one' work but that they would meet to discuss work with her mother

and grandmother. This was not recorded at the Child in Need meeting on the 15th December. A referral was made to CROP by the placement support worker on the 28th November 2011 to provide support for Autumn's mother and/or grandmother. The referral was accepted. This was not mentioned at the Child in Need meeting on the 15th December.

6.7.24 Concern about the assault on Autumn 25th November 2011

6.7.25 Autumn's mother contacted the CRW to report a further injury to Autumn following a missing episode. She added that Autumn looked petrified when she saw a particular make of car. Autumn's mother also reported that she was wetting the bed again. There is no record of any consultation with a manager or other form of action having taken place as a result of these concerns.

6.7.26 Autumn started at the PRU on the 1st December 2011 and was reported to settle well. There are no recorded notes in the chronology from the PRU.

6.7.27 Support for Autumn

6.7.28 Autumn was seen more regularly during this period by the local CSE support service, the placement support worker and the community resource worker. The ESW service also became involved in taking Autumn to School. The local CSE support service were able to undertake a planned and supervised piece of work with Autumn. This work focused on CSE and was discussed at the Child in Need meeting on the 15th December. At this point there appears to be a blurring of roles between the placement support worker, the community resource worker and the local CSE support worker.

6.7.29 Supervision for the Community Resource Worker 9th December 2011

6.7.30 This supervision record confirmed a decision from Senior Management to support Autumn to continue to live with her grandmother. There appears to be no record of any discussion around specific incidents or events that had happened since the last supervision on the 3rd November. The chronology and the core assessment were still outstanding.

6.7.31 Events over the 11th to 13th December 2011

6.7.32 On the 11th December Autumn was found in a house with a 33 year old Asian male who was issued with a Harbourers' Warning. Autumn was also found to have taken money from her great Grandmother. Autumn was interviewed about this on the 12th December with grandmother acting as the appropriate adult.

6.7.32 The CRW saw Autumn on the 13th December. Autumn said that she felt more settled at her grandmother's home. Autumn denied that anything had happened in the house in which she had been found on 11th December. The CRW expressed concerns to Autumn about her ability to recognise and keep herself safe in risky situations. This was not referred to in the Child in Need minutes on the 15th December.

6.7.33 The Child in Need meeting on the 15th December

6.7.34 The Child in Need meeting proceeded without family members, without health representation and without apparent management oversight. As has already been demonstrated a lot of what happened in the previous month appears not to have been considered and information known to individuals or others not brought forward. This information therefore had no impact on the assessment or the action plan.

6.7.35 At this point a further parallel process was in place. Autumn was being actively considered

by strategic leaders. Following the challenge event in November 2011, Autumn was identified as one of the key priorities and highest risk cases in relation to CSE. There is no evidence that these two parallel processes were connected or joined together.

6.8 16th December 2011 to 30th January 2012:

6.8.1 Support to Autumn over this time

6.8.2 The local CSE support service worker saw Autumn on three occasions over this period and was able to undertake planned work. Autumn was more settled at the PRU and attending regularly. The placement support service provision was not accessed and this support was withdrawn. Autumn's placement at the PRU was coming to an end.

6.8.3 Autumn had little contact with her mother and sister. Autumn's grandmother said that Autumn's mother was sometimes drunk when she visited. Autumn was distressed by contact with her mother at Christmas. The police agreed a revised missing strategy with Autumn's grandmother on the 20.01.12. Autumn's main groomer was in prison during this time.

6.8.4 Supervision - CRW by team manager 17.01.12

6.8.5 Risks to Autumn were identified as reducing due to her placement at her grandmother's rather than due to Autumn's main groomer being in prison. A more consistent attendance pattern at the PRU meant that Autumn was being seen regularly. A view was taken that an exit strategy could now be looked at, presumably with a view to closing the case. This demonstrates a complete failure to understand the nature of the risks that Autumn was being exposed to. The chronology and core assessment had still not been undertaken.

6.8.6 Meetings and records missing from the chronology

6.8.7 Autumn was referred to as being discussed at both safeguarding and MAACSE meetings but these meetings are absent from the chronology, and minutes are not currently available. It is recorded that the chair of the MAACSE asked about a secure placement and the CRW said that this was not an option. There were six missing episodes recorded at the Child in Need meeting on the 30th January which are not recorded at all on the file.

6.8.8 Child in Need/CSE meeting 30th January 2012

6.8.9 This meeting was chaired by the CRW with Autumn's grandmother, her secondary school, the local CSE support service and the police in attendance. Autumn had been told that her father was terminally ill. The school was going to apply for an extension to the placement at the PRU. There is no recorded discussion of the MAACSE or safeguarding meetings held earlier in the month. The meeting recorded Autumn as at medium risk of CSE. Again it is unclear what this assessment was based on.

6.9 January 30th to March 12th 2012:

6.9.1 30th January to 3rd February 2012

6.9.2 Information was received by the police that Autumn had performed oral sex on an Asian man in the park. This was classified as prostitution in police records. Autumn went missing the following night and this was assessed by the police as low risk. No return forms were completed. Her grandmother was visited by the placement support worker on the 1st February and she told the PSW that she could not keep Autumn safe. Autumn's grandmother stated that Autumn had got hold of a mobile phone and this had led to an escalation of missing episodes. Her

grandmother also reported that Autumn had started wetting the bed again. Autumn went missing later that day and Police seized her phone when she returned.

6.9.3 On the 2nd. February the local CSE support service worker completed a second risk assessment which assessed the CSE risk to Autumn as high. Again there is no record of this being shared with any other agency. On the same day the placement support worker had a management discussion which confirmed a continuation of the approach to support grandmother. It also sought to maintain Autumn there rather than remove her. Autumn and her grandmother had a meeting at CAMHs on the 3rd February.

6.9.4 Move to a more forensic and interventionist approach by West Yorkshire Police

6.9.5 During this period the police seized underwear and phones from Autumn. They also visited alleged perpetrators directly and issued further Harbourer's or Child Abduction Warning Notices. Autumn's uncle had found pictures, numbers and contact details on Autumn's laptop and this laptop was handed to Police.

6.9.6 Direct assaults and credible threats to the family

6.9.7 The police installed alarms at Autumn's grandmother's house and the fire service fitted alarms and protection from petrol bombs to the letter box On the 15th February, Autumn's uncle was assaulted by three masked men with a baseball bat. The family believed that the three suspects wanted to retrieve Autumn's laptop and gave this information to the police. Her uncle was left with 18 stitches in a head wound and with a swollen arm and leg.. Autumn also told the local CSE support service project worker that she had suffered broken ribs. It does not appear that this was reported or investigated any further, nor was there a medical assessment of Autumn's injuries.

6.9.8 Supervision CRW by Team Manager on the 17th February

6.9.9 This meeting failed to acknowledge the level of direct threat and risk to Autumn and her family. It would appear that Autumn's safety was marginal in this current environment. There was still no core assessment or chronology completed. There was another reference to a future MAACSE meeting which the CRW was not invited to.

6.9.10 7th to 9th March 2012

6.9.11 A further Harbourer's Warning was issued by the police. Autumn was also video interviewed and DNA swabs were taken. The main groomer was visited by police on the 8th March. On the 9th March, the school asked Children's Specialist Services for Autumn be placed out of the authority area or in secure accommodation, as they felt that they were no longer able to safeguard her. The reason cited for not progressing concerns to the child protection level was grandmother's co-operation. In this exchange the school was told that Autumn's worker was a community resource worker and not a social worker.

6.9.12 Child in Need meeting 12th March 2012

6.9.13 This meeting was chaired by the community resource worker with Autumn's mother and grandmother in attendance. The school, local CSE support service, police, the placement support worker and CAMHs also attended. The school nursing service gave their apologies. This meeting failed to address the reality of the threats to Autumn and her family.

6.10 12th March to 16th April 2012:

6.10.1 Autumn's school attendance continued to be a concern at this time. Autumn was excluded for five days and described as 'causing havoc' in school. This resulted in her grandmother having to take unpaid leave. There is no record of anyone contacting the school to question this. Autumn reported in her CAMHS session on the 20th March that she no longer wished to attend her school.

6.10.2 <u>On-going concerns about Autumn</u>

6.10.3 On the 14th March 2012 the local CSE support service received a report from another student about Autumn being at parties that she was at. This is not recorded as having been passed on to Children's Specialist Services. Autumn was still going missing and on the 20th March her grandmother reported to the police vulnerable victims' coordinator that the situation was terrible.

6.10.4 On the 27th March Autumn's grandmother mentioned to local CSE support service that Autumn had three kidneys and was being referred to a specialist for her 'water problems'. There is no record of this referral having been made. On the 30th March Autumn went missing with another young person. They said that Autumn had gone to a park to do 'sexual stuff'. Autumn denied this at interview. Autumn was recorded as going missing on six occasions in April 2012 prior to the Child in Need meeting.

6.10.5 <u>Attendance at CASH Sexual Health Clinic March 2012</u>

6.10.6 Autumn attended for a first appointment on the 16th March 2012. Autumn is recorded as telling the sexual health worker that she had been sent by her worker. Autumn later told the overview author that it was her grandmother who had organised the visit. At this first session Autumn disclosed a rape in November 2011. Autumn also said that she has been sent for an implant as she keeps going missing and her social worker was concerned she was being groomed. Autumn said she was not being groomed and was not having sex at that point. The worker took a sexual health screen and Autumn had a pregnancy test which was negative. Autumn agreed that the sexual health worker could discuss the situation with her social worker and she agreed to come back to see her again in two weeks.

6.10.7 The sexual health worker had a telephone conversation with the community resource worker on the 26th March prior to Autumn attending the clinic for the second time. It is recorded by the sexual health worker that the CRW told her that there were concerns about Autumn in relation to CSE. She further reported that Autumn's grandmother was worried about her vulnerability. Autumn's grandmother said that she had been found giving oral sex, and also found in a thirty year old males flat. The CRW also said that there were concerns about young girls being encouraged by groomers to have implants fitted. There is no evidence that this information was discussed with a manager or a safeguarding adviser at this point.

6.10.8 Autumn attended the clinic again on the 26th March. Autumn said that she had a 15 year old boyfriend. She was assessed as Fraser competent and the implant was fitted. The sexual Health worker told Autumn that her sexual health screen was negative.

6.10.9 <u>On-going support for the family March 2012</u>

6.10.10 CROP, now known as PACE, agreed to take a referral to support Autumn's grandmother on the 14th March 2012. The local CSE support service saw Autumn on the 15th March and ran a structured session on grooming. They talked directly to Autumn about whether she knew anyone being groomed, Autumn didn't respond to this. The project worker said Autumn could talk to her when she was ready. Grandmother and Autumn were seen by CAMHS where they talked about

mother's neglect of Autumn and explored the time she had spent living with grandmother. Information was received on the 26th March that Autumn's father had a terminal illness and perhaps only had 6- 8 weeks to live. He subsequently died in February 2015. There was a note on the CAMHS record to say that he was admitted to a Hospice on the 29th March.

6.10.11 Supervision of the CRW from her Social Work Manager on 21st March 2013

6.10.12 This session reviewed Autumn not being in school and her grandmother having to take unpaid leave. Contraception was reported as being issued without apparent reflection on the wider context. The police's investigation of groomers and engagement with CAMHS was noted and things are seen to 'be moving forward'. The core assessment and chronology were still outstanding.

6.10.13 Child in Need meeting - 16th April 2012

6.10.14 This Child in Need meeting proceeded with only the CRW, the local CSE support service and the YOT worker present. The YOT worker had not yet met Autumn. Apologies were given to the meeting from the school nursing service, the school, CAMHs, placement support, the police, Autumn's mother and grandmother. At the time that the meeting was held, Autumn was missing. Autumn was described as doing ok, despite continuing to go missing, the issues with school attendance and the stresses on her grandmother. A pattern was emerging of sporadic and poor attendance at meetings and key agencies had lost faith with their ability to have any impact on the planning for Autumn. At this point, both the school and the police expressed the view that Autumn should be accommodated, either out of the Authority or in secure accommodation. Autumn had also been told that her father was terminally ill. No mention is made of the contraceptive implant which had been fitted. There seems to be no connection between this meeting and the MAACSE meeting. The actions seem to report the actions of the previous meeting with no progression. The local CSE support service records state that there were no updates from other agencies.

6.11 From 16th April to 25th May 2012:

6.11.1 An on-going forensic approach was taken to the investigation during April 2012. Underwear and phones were seized by the police during this period and an alleged perpetrator was interviewed. On the 27th April an officer from the Safeguarding Unit visited the Local CSE support service to arrange to interview Autumn. This forensic approach did not include any medical examination of Autumn.

6.11.2 Further concerns about Autumn during April 2012

6.11.3 Autumn alleged an assault by two other females on the 23rd April 2012 to the police. Autumn continued to go missing. Autumn requested the removal of the implant on the 25th April. Autumn talked about her mother at the session with the local CSE support service on the 25th April and in the CAMHS session on the 26th. Autumn spoke about not being wanted and her mother not wanting contact with her at this point in time. There were delays in securing Autumn another place in alternative Education provision.

6.11.4 Supervision between the CRW and her Team Manager 3rd May 2012:

6.11.5 The chronology was identified as being complete and the core assessment 'just needs writing up'. Concerns were expressed that Autumn's grandmother might lose her job due to the stresses of caring for Autumn. Things were referred to as 'being stable but by no means safe'. Services were referred to as' beginning to take effect and maintain subject child with family members'. The outcome was to 'continue the planning and strategic multi-agency response to

support subject child at grandmothers'. This assessment seems to bear little relationship to Autumn and grandmother's lived experience and the level of engagement with other services.

6.11.6 An escalation of concerns from 3rd to 7th May 2012

6.11.7 Autumn went missing for five nights in a row from the 3rd to the 9th May. Autumn was discussed at a MAACSE meeting on the 10th May. She went missing again that night. Autumn went missing again on the 14th & 15th May. On the 15th May, following a further MAACSE meeting that morning, the police took Autumn into Police Protection and the Duty Inspector recorded their concerns that she could be killed. A follow up letter sent to Children's Specialist Services cited evidence from other areas that children needed to be removed in order to promote disclosures.

6.11.8 Children's Specialist Services took legal advice and decided to continue with the support to Autumn's grandmother. The team manager is recorded as stating they do not believe it would meet the threshold for child protection as grandmother is 'working proactively with us'. On the 16th May at a local CSE support service meeting grandmother was recorded as saying that she has been signed off from work with anxiety and depression.

6.11.9 The police and Children's Specialist Services managers held a meeting on the 17th May 2012. They agreed to set up a strategy meeting and to explore the possibility of Autumn moving to her maternal Aunts in the south of England for a period of respite. Police met Autumn at the local CSE support service on the 17th May.

6.11.10 The strategy meeting on the 24th May 2012

6.11.11 This meeting was chaired by a Child Protection Coordinator and attended by a wide range of professionals. The police disclosed forensic evidence of the sexual abuse of Autumn and stated that they now had sufficient evidence to make arrests. The meeting focused on the immediate and medium term protection of Autumn and how best to engage with Autumn to secure this. There was a greater understanding of how Autumn was being groomed and silenced. An agreement was reached to initiate a section 47 investigation and to provide a programme of activities to reduce Autumn's contact with her abusers. A further meeting was scheduled for the 29th June 2012.

6.11.12 It is not recorded that a section 47 investigation was ever initiated by Children's Specialist Services. A discussion took place as to whether a social worker should now be allocated to the case given the complexity of the issues. It was agreed that a social worker should be involved with the visit to the aunt's home in the south to assess her viability as a carer. Concerns were still expressed about the validity and value of working under a child protection approach, on the basis that Autumn's grandmother was working cooperatively. The plan was discussed with Autumn by the community resource worker on the 25th May and the local CSE support service worker reported that Autumn was very angry about this at a joint session. Autumn did agree that her safety should come first and that she would want to come back.

6.12 Subsequent events leading to Autumn's accommodation in residential care:

6.12.1 On the 29th May Children's Specialist Services agreed Autumn should move as quickly as possible to her Aunt's. Her risk of significant harm was acknowledged if she was not moved. By the 1st June the plans for Autumn had changed significantly and she was taken to a foster placement under S20 of the Children Act 1989. This meant that there was no court order, it was based on an agreement between Autumn's mother, who retained parental responsibility, and the Local Authority. Autumn returned to her grandmother's home from the foster placement on the

4th June. She was probably transported by groomers. Autumn agreed to a video interview with the police on the 7th June 2012. At this interview Autumn disclosed a number of rapes. Autumn was placed in the residential unit on the 8th June 2012.

6.12.2 Assessment of maternal aunt and initiation of care proceedings:

6.12.3 Following a LAC Review with a care plan for Autumn to be placed with her Aunt, on the 16th May 2013 Children's Specialist Services took a decision not to proceed with the plan as the viability assessment was not positive. Autumn was informed of this decision over the phone on the 22nd May, which her mother agreed to. Both the police and the residential unit expressed concern that Autumn was told about such an important decision in this way. Autumn still feels that this was an inappropriate way for her to be told about such an important decision.

6.12.4 At the LAC review held on the 12th July 2013, Autumn stated that she didn't intend staying at the residential unit until she was 18. On the 16th January 2014, the police initially raised concerns about Autumn's grandmother undermining the safety plan for Autumn and questioned whether a care order might be needed. Children's Specialist Services took legal advice and agreed to supervise contact in the interim. At a joint meeting on the 29th January, Children's Specialist Services confirmed to the police that they had received advice that the local authority did have grounds for a Care Order. This was further discussed between Children's Specialist Services and Legal on the 10th February 2014 and it was agreed that on balance the section 20 agreement should continue

6.12.5 On the 9th April 2014, following a discussion with a senior manager, the team manager recorded that the decision was now to initiate care proceedings to safeguard and secure Autumn in the placement. It was also agreed that work would be undertaken over the next 12 months with Autumn's aunt, to try and create a more viable placement. The family were informed of the decisions on the 23rd April, and Autumn was told on the 29th April 2014. All were opposed. Autumn made a complaint to the Children's commissioner. A further LAC review was held on the 16th May 2014 where Autumn recorded her disagreement about the decision and talked about the stress it caused and the impact on her studies.

6.12.6 The reasons for issuing the proceedings were sent to Autumn by letter on the 28th May 2014. The first court hearing was held on the 28th July and a Children's Guardian was appointed. The order was opposed by the family and by Autumn. A final hearing was ordered for before Autumn's 17th Birthday. On the 7th August the viability assessment on Aunt was discussed by the social worker and their team manager. An addendum report was agreed to make the reasons for the non-viability of the placement clearer. On the 16th September the judge rejected the application and made no order.

7. Key Findings - resulting from concerns and actions arising from the consideration of the integrated chronology and the Independent Agency Reviews in relation to Autumn's journey through services

7.1 Pivotal incidents – key findings:
Overview Report Author (ORA)

7.1.1 1. The assessment of serious risk in the Summer of 2010

ORA. - Barnardos assessed a serious risk in the summer of 2010 and passed this on to the local CSE support service, who record receiving this information. This information does not appear to be passed onto anyone else and the service does not appear to make any more use of it. This

means a significant piece of information was lost and was not part of any subsequent assessment. An opportunity for earlier intervention was therefore also missed at this point.
Key Finding: Failure to follow safeguarding procedures, information not shared across the child protection partners

7.1.2 2. Disconnections in the core assessment in November 2010

ORA - At this point in time there were already concerns in relation to Autumn at school dating from the summer. None of these concerns are included in the core assessment.
Health - Autumn had intermittent contact with school nurses in relation to her enuresis. This was partly due to her mother failing to take her to appointments. Services were not proactive about pursuing these concerns about Autumn and the issues remained unaddressed and unresolved.
Health - Concerns remained in relation to the impact of neglect, family and other stress and sexual abuse on this condition.
ORA - Barnardos had already assessed Autumn as high risk at this point and the school had made a referral to the local CSE support service.
Local CSE support service - There were delays in the local CSE support service making contact with Autumn and her family following both referrals. Both Autumn and her family expressed doubts as to how helpful this work was to Autumn.
Local CSE support service - Project workers identified concerns and these concerns were not routinely discussed with managers. They were often not communicated to Children's Specialist Services, sometimes not recorded at all, or not recorded with sufficient detail. Assessments of risk were not communicated to Children's Specialist Services.
ORA – Although Autumn's mother, Autumn and her sister were seen as part of the core assessment, the focus of the assessment was primarily on the concerns about people posing a risk in the immediate family. None of the CSE concerns about Autumn which were already apparent and available were picked up in this assessment. The worker appeared to take what they were told at face value.
Key Finding: The overall quality of the assessment was poor, lacking focus and missing significant information.

7.1.3 3. The Initial Assessment on the 14th April 2011 and the meeting of the significant harm threshold.

ORA - The language of this assessment framed the concerns around Autumn's behaviour and actions rather than what might be happening to her. No CSE assessment tool was used to assess the CSE concerns that were raised by School and family.
WYP - There was a view within the police in 2011 that troublesome teenagers going missing were diverting attention from other strategic priorities in relation to serious acquisitive crime. Insufficient attention was paid in 2011 to perpetrators and the securing of forensic evidence. Not all missing incidents were responded to and not all of these incidents were shared appropriately with Children's Specialist Services.
CSS - Regardless of the community resource worker's undoubted commitment, the case should have been allocated to a more experienced worker with a social work qualification. Autumn was not allocated to a qualified Social Worker until a joint allocation was agreed in May 2012.
CSS - This was not clear to other agencies, who refer to Autumn having a Social Worker prior to this time. There was no recorded consideration that the case was exceeding the nature of work, level of risk and complexity which would be appropriate for a Community Resource Worker. Work was recorded in a system which meant that there was no process for team manager authorisation.
ORA. - In hindsight the Children's Specialist Services IAR author felt that at this point sufficient information and knowledge existed about Autumn's vulnerability and risk to justify a strategy

discussion or meeting with the police as part of a section 47 inquiry. The outcome was to offer support to Autumn and her family. There was a missed opportunity here to put a safeguarding frame around the concerns about Autumn prior to the rape which occurs three weeks later.
Key Finding: The overall quality of the risk assessments within the assessment process was poor and failed to take into account the holistic evidence available about Autumn and the harm she was experiencing. This resulted in Autumn's circumstances not being considered within a safeguarding framework.

7.1.4 4. The reporting of the rape in early May 2011

ORA - The school, the police and the GP were informed about this rape directly by Autumn and her mother.
School - Autumn's school failed to follow child protection procedures and report the allegation of rape to Children's Specialist Services when it was reported to them by Autumn and her mother.
GP - A GP failed in their child protection responsibilities to safeguard Autumn following her disclosure of rape by not seeking medical attention for her, or for reporting the assault to Children's Specialist Services.
WYP - The police investigation team followed standard procedures in investigating the rape allegation. There was no supporting evidence to corroborate the crime and based on this and Autumn's withdrawal of her allegation the police decided that no further action could be taken. However, the police then failed to pass the rape allegation made by Autumn onto CSS within the timescales set out in the safeguarding procedures. The police also defined Autumn as unreliable and as someone who would lie to them at this time and this was communicated to other agencies.
All-agencies - Autumn was not referred to any paediatrician as a result of safeguarding concerns whilst she was in the Bradford District, as a paediatric assessment was never requested. There were no discussions by the police or Children's Specialist Services with paediatricians about Autumn, in the context of either of the strategy meetings which took place, or at any other time.
ORA - Autumn was 13 years old at this time. No one followed the expected safeguarding procedures in relation to this incident.
Key Findings: There was a failure to follow safeguarding procedures by the key agencies to whom Autumn made her allegations of rape to. This led to a further multi-agency failure to ensure that Autumns physical and sexual health needs were assessed and her needs met.

7.1.5 5. Failure to hold strategy meetings or discussions.

WYP & School - Children's Specialist Services were informed of the rape incident by the police on the 27th May 2011, which was more than 3 weeks later. Autumn's school does not appear to have communicated their information about the rape to Children's Specialist Services.
CSS - For the IAR author, information which was described as 'intelligence' was not converted into a live and dynamic assessment of the risk to Autumn and was treated discretely. This included information of significant concern which appears not to have been considered by the Child in Need meetings.
CSS - A core assessment requested and agreed to in April 2011 had still not been completed in June 2012. No detailed chronology was ever completed. It would not have been appropriate for the Community Resource Worker allocated to Autumn to undertake these tasks.
CSS – Further - a section 47 investigation agreed to on the 24th May 2012 following a strategy meeting appears not to have been undertaken. When Autumn was taken into Police Protection in May 2012, Children's Specialist Services decided to return her to the care of her grandmother.
ORA - There is no evidence that the workers directly involved in supporting Autumn from the local CSE support service were ever made aware of the Police Protection action or factored this into their risk assessment.

WYP - The police reported to a later Child in Need meeting that Autumn was known to lie. The police IAR authors note that, in later interviews when she was living away from the Bradford area, Autumn disclosed that she had in fact been raped at this time and that the rapist was her main groomer.
School - The school IAR reports that they were told by West Yorkshire Police that the matter had been referred to Children's Specialist Services. The school took no further action. The GP IAR author characterised the GP's recorded response as 'seriously deficient' and the author informed the September 2015 meeting of the Review Panel that a fitness to practice referral had been made by them to the GMC in relation to the way the GP had responded to this disclosure. The Children's Specialist Services IAR author noted that Children's Specialist Services and the police did not hold a strategy discussion about this allegation when it was made at the start of May.
ORA - In addition key information about the history, nature and level of risk Autumn was exposed to, was not given to the CSE strategy meeting in June and was therefore not addressed at the meeting.

In his summing up in the sentencing remarks in the criminal case the Judge stated:

'By May 2011 Autumn was trying to extricate herself from (her main groomer) and she refused to continue supplying drugs for him. His response was to exert yet more forceful and violent influence over her which culminated in him raping her… In doing that he took away her virginity and succeeded in bending her to his overbearing will.'

ORA - This lack of appropriate response represents a serious systemic failure to safeguard Autumn at a basic level of compliance with longstanding procedures and expectations and the minimum standard of response which Autumn and her mother were entitled to expect from services.
Key Finding: There was a failure to apply existing safeguarding thresholds in this case. There was a parallel process in place which meant that CSE cases were dealt with by a different strategy meeting process distinct from a mainstream safeguarding approach. This was exacerbated by the confusion over roles and responsibilities, the status of the case and the system in which the case was being managed. These misperceptions compounded the failure to communicate risk effectively and follow the safeguarding procedures.

7.1.6 6. Background to the move to Grandmother's house in November 2011

ORA - The decision to 'enable and support' Autumn at her grandmother's home in November by Children's Specialist Services was flawed. Autumn's Grandmother was not able to support Autumn to stay in School or to prevent her from going missing.
- At this point the characteristics of Autumn's case had already been discussed by the Safeguarding Board Challenge event and the school and the police were expressing concerns that Autumn's safety from harm could not be assured with her continuing to live in Bradford.
- Children's Specialist Service continued with this approach on the basis of a belief that this was in Autumn's best interests without appropriately assessing what was happening to Autumn or the escalating concerns of others. This unchallenged belief led to a significant delay in effective action being taken to safeguard Autumn and in her exposure to continuing significant harm.
Key Finding: There was a failure to take all relevant information into account by Specialist Children's Services in deciding to support Autumn to stay with her grandmother. This resulted in her remaining at risk both physically and through sexual exploitation and delayed her protection at a time when the local Safeguarding Children Board and two other agencies had identified her as being at significant risk.

7.2 A summary of Family engagement:

7.2.1 The family's engagement and contact with services: Early identification of concerns

Autumn's mother failed to take Autumn to her appointments at the continence clinic and they were unable engage with Autumn in relation to her enuresis. Autumn's mother regularly took Autumn to the GP but did not engage with Autumn in the work with CAMHs. The School Nursing Service had contact with Autumn. Autumn's mother attended early meetings with the school about behaviour and attendance, and Autumn's mother reported Autumn missing on a regular basis.

7.2.2 The family's engagement with Child in Need meetings

Autumn's mother and stepfather attended the early Child in Need meetings. Autumn's grandmother attended some of the later Child in Need meetings. The family took proactive steps to prevent Autumn running away, to report her missing, and to try and find her when she went missing.

7.2.3 The family's engagement in evidence gathering

Autumn's mother, stepfather and uncle kept a diary, phones, laptops and records of names. Autumn's grandmother actively participated by keeping Autumn's clothing for forensic analysis when she had been missing and keeping phones. The family felt it was important to be involved in the gathering of evidence as in that way they could contribute to seeking to protect Autumn.

7.2.4 The family's engagement with Autumn's accommodation by the Local Authority

Autumn's mother agreed to the Local Authority accommodating Autumn under section 20 of the Children Act. The family supported Autumn in her placement, visited her regularly and took her away on holiday. Autumn's aunt agreed to be assessed to provide an alternative placement for Autumn but the decision was eventually taken not to proceed with this placement. The family, including her birth father, strongly supported Autumn's opposition to the Local Authority application for a Care Order. The family found it difficult to understand and support the protection plan put in place to protect Autumn from her abusers. In contravention of the protection plan, Autumn's grandmother did provide Autumn with an internet enabled smartphone during a contact visit.

7.2.5 The provision of support for the family

Both Autumn and her family were provided with regular support from a range of agencies whilst Autumn was in her home community. This support was not always well co-ordinated and did not have a primary focus on assessing risk and safeguarding Autumn. A coordinated approach between children's specialist services and the police provided a lot of practical and financial support to the family whilst Autumn was in her residential placement, to ensure that they were able to stay in touch with Autumn.

Autumn's grandmother's and stepfather's employers were positive and helpful about being flexible to working arrangements. This enabled her grandmother to care for Autumn, and enabled her grandmother and stepfather to visit Autumn.

PACE provided support to Autumn's grandmother from April 2012 and the CAMHs service undertook some joint work with Autumn and her grandmother. Autumn's mother did not access

support from PACE and did not participate in the CAMH's sessions despite Autumn wanting her to.

8. Exploring and seeking to understand the initial delay and failure to safeguard Autumn in her home community:

This section will explore and seek to explain why there was a failure to recognise the harm, the delay in safeguarding Autumn and why the help was framed in the way it was.

8.1 Reason 1 - The procedures and processes in place in Bradford between 2010 and 2012

West Yorkshire Safeguarding Children Boards agreed a shared protocol and practitioner guidance for safeguarding children and young people from child sexual exploitation in April 2008. Bradford, alone amongst the West Yorkshire Authorities, issued an additional chapter of guidance in May 2010 in response to the Government Guidance on Child Sexual Exploitation issued in 2009.

In 2008 Bradford had a CSE Co-ordinator in post and also ran regular MAACSE meetings. This post was lost before 2010 and the MAACSE meetings were also no longer running by 2010. The additional chapter was missing from TriX procedure updates between November 2010 and July 2012. The revised procedures reflected the development of the Bradford Multi-Agency CSE Hub, which was established in January 2012.

Bradford was therefore proactive in its procedural response to CSE and the Safeguarding Board was one of only 25% of Boards to have procedures in place in 2011 when the University of Bedfordshire undertook the research for 'What's Going On? However, while the procedure was in place, professionals at a multi-agency level were not always aware or confident in how it worked and were therefore not always compliant with practice expectations.

8.2 Reason 2 - Issues of belief and understanding

As the Oxfordshire Serious Case Review (2015) which covers a similar time frame to Autumn points out:

'There have been similar cases to those in Oxfordshire, most notably in Rochdale, Derby, Bristol and Rotherham. The same patterns of abuse are seen, the same views of victims and parents, and similar long lead-ins before effective intervention. For all this everywhere to be a result of inept, uncaring and weak staff and leaders who need to go, seems highly improbable. The overall failings were those of a lack of knowledge and understanding around a concept (of CSE) that few understood and where few knew how it could be tackled, but also of organisational weaknesses which prevented the true picture from being seen. It is important that this is recognised so organisations can, and can continue to, get it right on CSE, and can respond better when the next new challenge occurs'.

Bradford had a better knowledge of CSE at this time and was one of a minority of areas which had policies and procedures in place to respond to the issues. Yet we still see the same pattern of long lead in before intervention. The nature of belief, around both the priority for and the nature of the response at the time, provides some of the explanation.

In 2010 and 2011 West Yorkshire Police, along with other forces, did not prioritise intervention into this type of crime. There was also a broader belief that children involved in this kind of harm were actively consenting and choosing to become involved. In effect, no crimes were being committed. The focus of help should be to support the family and the child to keep themselves

safe and to try and divert them from engaging in these activities. Children's Specialist Services were clear about their legal responsibility to uphold family life and to intervene where possible to support families to stay together. They were aware of the evidence base which associates becoming a Looked After Child with poor outcomes.

However there was also a belief that the safeguarding processes and procedures were most effectively applied to familial harm. Consequently, it was believed that if the family was cooperating and supportive than a safeguarding threshold was not met. This was irrespective of the harm Autumn might be suffering outside of her family, in her local community. The commitment to supporting Autumn within her family home and local community and the concerns about placing her outside her family and away from Bradford were key causes in the delay in safeguarding Autumn. These beliefs drove decision making at a senior level and key information, which should have challenged this view, was not included into assessments and plans, particularly from November 2011 onwards.

These issues were a key focus of the dynamic assessment undertaken by the police and Children's Specialist Services in 2013. Key staff involved in these decisions acknowledged that on the basis of hindsight and further reflection, they would have made different decisions at this point in relation to Autumn, and have subsequently carried this learning through into their practice.

8.3 Reason 3 - Early assessment and intervention with Autumn and her family

There were a constellation of concerns relating to Autumn and her family which were recognised but not sufficiently assessed or addressed prior to 2010. These included:

- Appropriate assessment and intervention into her enuresis.
- Appropriate assessment and response in relation to the disclosures Autumn made about physical assaults on her by her mother.
- Appropriate assessment and understanding of Autumn's experience of her family and the core dynamics within it.
- Appropriate assessment and response in relation to her contact with People Posing a Risk.

There was knowledge, awareness and concern about these issues and there was communication between Health services, Autumn's school and Children's Specialist Services about these concerns. However these concerns were never brought together in a holistic picture of Autumn's experiences, needs and patterns of behaviour. A chronology, which would have enabled agencies to see the bigger picture as part of a common assessment process, was never completed. An assessment undertaken as part of a Core or Common Assessment Framework could have assisted in bringing this information together and may have helped to contextualise the safeguarding concerns. It is not clear at this point why a CAF was not undertaken as part of a process of clarifying concerns and establishing a threshold of need as it was an established part of Bradford's Safeguarding Procedure at this point.

8.4 Reason 4 - Information being lost, not shared or misrepresented as concerns grew, undermining the assessment process:

Records in relation to concerns about Autumn and her disclosures about her assaults by her mother were not received by the Secondary School from the Primary School.
Barnardos assessed Autumn as at high risk of CSE in July 2010 when she was 12. They passed this on to the local CSE support service and included information about text messages being sent

from a 30 year old. This information was not shared further and was then lost to future assessments.

Concerns which had been identified by Autumn's school, health services, the voluntary sector and the police were not shared at the initial CSE strategy meeting in June 2011. A police officer expressing the view that Autumn was known to lie was accepted unchallenged. The configuration of, and attendance at, subsequent Child in Need meetings also meant that important information and assessments were not considered by these meetings, in particular the meeting in April 2012.

A key feature of the first learning event, attended by frontline practitioners and managers directly involved with Autumn, was the lack of a coherent understanding and consistent information and knowledge that key people had about what was happening to Autumn. It was clear that the fractured and inconsistent sharing of information had a significant impact on the way practitioners understood Autumn's circumstances and how they viewed each other. This disconnection reflects the issues described in relation to information sharing and the lack of any appropriate assessment.

8.5 Reason 5- A failure to put a safeguarding framework around Autumn

In particular this includes a multi-agency failure to respond appropriately to Autumn's disclosure of rape on the 4th May 2011. Decisions were made about the rape of Autumn in May 2011 by her school and her GP which did not meet their child protection responsibilities of a safeguarding approach to Autumn's disclosure. The police's failure to refer the allegation of rape was influenced at that time by Autumn's retraction of the allegation. However, it is now acknowledged by the police that a timely referral should nevertheless have been made. No strategy discussion ever took place to assess the rape. There was no paediatric input into this incident as they were not involved by other partners and were therefore unaware of Autumn. This also meant that the issue of Autumn's consent to a forensic medical, and whether and how consent might be informed, was not thoroughly explored.

There are other pivotal moments when the police and Social care could and should have considered holding a strategy discussion and initiating a section 47 investigation, and this was not done.

The IAR Author for BDCFT notes that at the Child in Need meeting held on the 21st July 2011 that there are 10 indicators of risk of CSE present in this meeting as identified using the West Yorkshire Child Sexual Exploitation Risk Assessment Tool (September 2014). The author notes that Autumn was still only 13 years and 9 months old at this point and concludes that there was sufficient information here for consideration to be given to a section 47 investigation.

The IAR Author for Children's Specialist Services takes the view that significant episodes during 2011 did not prompt management discussion or consideration of strategy discussions or section 47 enquiries.

The Police IAR authors also stated that an opportunity to discuss Autumn as part of child protection procedures was missed at this point. They further note that opportunities were missed during 2011 and that the handling of the missing episodes and other incidents were inappropriate. They state:

'The quality of risk assessments undertaken by West Yorkshire Police in relation to Autumn's missing episodes at this point did not always reflect the risk she was exposed to or her vulnerability. This indicates a lack of awareness of links between CSE and children who are

reported missing on a regular basis at the time and an inconsistent application of the ACPO Guidance on the Management and Recording and Investigation of Missing Persons 2010'.

The OFSTED Thematic Inspection on the Sexual Exploitation of Children (2014) also notes that:

'Indeed as our findings show, part of the problem lies in the fact that some professionals have simply failed to properly apply child protection procedures and processes to young people at risk of being sexually exploited.'

The author for Access and Inclusion - in presenting the report to the Panel characterised the response of the service to Autumn as inadequate and unacceptable in relation to the safeguarding concerns. There was a marked and sustained lack of involvement and engagement with Autumn and the school from Education Social Work and a lack of engagement in attending Child in Need meetings. There was no evidence of willingness to engage with or take on support work with Autumn. There was no evidence of analysis of Autumn not attending School. There was no evidence of transition documents or evidence of knowing about previous safeguarding concerns. Transfers between workers were not undertaken properly and not to an acceptable standard.

- It was agreed by the Review Panel, following the presentation of the initial draft of this IAR in September 2015, that the Director of Children's Services be briefed about its contents. **This was done**.

The consultation with sexual health services for contraception should have triggered a safeguarding response. Further advice and support should have been sought around the child protection concerns which were identified during that process. At all opportunities when a medical should have taken place, only forensic issues were considered not her health needs.

8.6 Reason 6 - A lack of professional curiosity and challenge

There were times when key information was taken at face value and individual professionals accepted what they were told without taking further advice or giving further consideration. Examples of this were:

- The failure to progress the possibility of a medical assessment with Autumn following the rape.
- Not progressing concerns, when Autumn reported assaults or appears to have been assaulted.
- Failing to respond appropriately to missing incidents.
- Not taking further advice with regard to the disposal of the used condom.
- Not taking advice about the information presented as part of the sexual health consultation, about Autumn being sexually exploited.

8.7 Reason 7 - A failure to contextualise and understand the grooming process and abuse which Autumn was subjected to in assessments and decision making

In common with a number of other areas, the process of grooming and exploitation which Autumn was subject to at this time were poorly understood. The procedure and assessment processes which might have informed this understanding do not seem to have been used.

The Oxford SCR (2015) talks about assessment focusing on "what the girls did rather than what was done to them" as being a key failure in assessment. This can be seen to have been operating with Autumn's case as the focus over this time was whether she was at school and when she was missing, rather than what was happening to her whilst she was absent from school and missing from home.

8.8 Reason 8 - A failure of management oversight and supervision as concerns escalated

The core assessment and chronology agreed within Children's Specialist Services were not completed in time and were given to someone not qualified to undertake them. The lack of an assessment meant that decisions taken at a higher level in the organisation were not rooted in an understanding of Autumn's circumstances. There is little evidence of any shared oversight between the police and Children's Specialist Services in relation to the co-ordination of support for Autumn whilst she was in her home community, and the investigation into her abusers proceeded separately.

The ESW Service had little grasp of what was happening to Autumn and there was a serious lack of consistency in the support and co-ordination of their work. There is evidence that management oversight within the local CSE support service was poor and that key assessments undertaken by that service, as part of the work with Autumn, were not shared with Children's Specialist Services.

Paediatricians were not engaged in the process by other agencies and health professional did not seek safeguarding advice and support in relation to concerns about Autumn.

Following Autumn's placement in the residential unit, the CSS IAR Author notes that family contact was not always maintained within expected timescales. There was a delay in assessment, decision making, and failures of communication around the consideration of maternal aunt as a suitable alternative carer for Autumn. There is reason to doubt the wisdom of issuing formal care proceedings prior to Autumn's 17th Birthday and an insufficient consideration given to the impact that this might have on her and her educational attainment

8.9 Reason 9 - The issue of Escalation within a multi-agency forum and the use of the escalation procedure - A growing conflict between the views of Children's Specialist Services, the police and the school about how best to protect Autumn and ensure her safety:

By November of 2011 the police and Children's Specialist Services had completely different views about how to secure Autumn's safety. The formal police view was that Autumn required secure accommodation. Children's Specialist Services decided to support Autumn's grandmother to have Autumn living with her.

This disagreement continued through to May 2012 when Children's Specialist Services returned Autumn to her grandmother's care from Police Protection. It is clear from the chronology that this was done without assessing what had been happening to Autumn, and the impact on her grandmother in the previous months leading up to this action by the Police. This conflict was the focus of the dynamic review between West Yorkshire Police and Children's Specialist Services. The review was undertaken in 2013 as part of reviewing the response to CSE between the two agencies.

8.10 Reason 10 - The over emphasis on co-operation and support from the family in decision making about managing the risk to Autumn:

Children's Specialist Services senior managers decided to support Autumn living with her grandmother. This was despite the evidence of her going missing, and missing School continually whilst she lived there for two weeks in October. This was when Autumn's Mother and step-father were away on holiday. This over emphasis on family support continued in decision making through to the spring of 2012, up until the strategy meeting held on the 25th May 2012. In the

supervision session of the CRW on the 17th January active consideration was given to an exit strategy from the support offered to grandmother.

8.11 Reason 11 - A confusion about processes, roles, identities and the status of meetings:

The CSE strategy meeting in 2011 and subsequent Child in Need meetings were described differently by different agencies. They were identified alternatively as Core Groups, team around the child, as safeguarding and strategy meetings and CSE meetings. This led to on-going misunderstandings and conflict about the threshold and focus of risk. This led to misperceptions over the level and nature of harm to which Autumn was being exposed to and what the appropriate actions to safeguard her were.

The CSE strategy meeting was outside the usual safeguarding processes. It was not an initial child protection conference and was not independently chaired. The failure to share information at this meeting may have been resolved if this separate arrangement for addressing issues of CSE had not been in place at the time. This was identified by the Review Panel in September 2015 as a continuing cause for concern. The Safeguarding Children Board was asked to clarify where the arrangements for meetings in relation to CSE sat within the mainstream safeguarding practice and processes.

In particular, the role of the community resource worker in Children's Specialist Services was not acknowledged or understood by other agencies. Agencies including the police, health services, the school and local CSE support service assumed that the CRW was in fact a qualified social worker. Whilst this is clear on the minutes of the Child in Need meetings it is not clear how the CRW referred to themselves and whether or not they made it clear that they were not a qualified social worker.

The level and complexity of the work involved meant that this work should not have remained allocated to a community resource worker and should have been allocated to a social worker as concerns and risks escalated. In particular the completion of a core assessment should have been undertaken by a social worker.

There was also some duplication and confusion about the support roles and work plans between the placement support worker the CRW and the local CSE support service worker. These were not co-ordinated and managed as clearly and as well as they could have been. The information available to the placement support worker and the local CSE support worker was not consistently considered at the Child in Need meetings or shared with the CRW.

8.12 Reason 12 - A lack of focus on perpetrators in 2010 and 2011

Despite the issuing of a number of Harbourer's Warnings, alongside the work of gathering of intelligence, little was done prior to 2012 to actively pursue and disrupt alleged perpetrators by the police and other partners.

8.13 Reason 13 - An over reliance on disclosure

There were a number of moments where it was apparent that workers were waiting for a direct disclosure from Autumn to trigger action. The Children's Commissioner (2013) identified this as an issue in her report 'It takes a lot to build trust'. Recognition and telling: Developing earlier routes to help for children and young people:

"It is important for professionals to notice signs and symptoms of children's and young people's distress at any age and not rely unduly upon the child or young person to talk about their abuse. A significant risk of reliance on verbal telling is that a child's silence or denial means that abuse is not pursued".

This is a consistent feature in the response to Autumn from the assaults by her mother, through to the rape and on-going abuse by the perpetrators.

9. Conclusions about Autumn's Journey through Services in her home community:

9.1 A picture of Systemic and Structural disconnections:

Confusion and disagreement existed between agencies in relation to the threshold and nature of significant harm, and in the focus of the work to be undertaken with Autumn and her family. There was also confusion about the status of meetings. Additional meetings about Autumn, such as discussions in the CSE Hub and as part of the MAACSE process, seem to have run in parallel process to the Child in Need meetings and did not connect to each other. The lack of a formal safeguarding framework around Autumn's circumstances contributed significantly to the confusion. Autumn never attended any of the meetings held about her.

Significant information known to agencies did not get to key decision making meetings, where the information could have impacted on the outcome. There seems to have been a consistent failure to assess Autumn's circumstances using an appropriate framework, whether that was a CAF, a core assessment, a specialist CSE assessment or in relation to sexual assault. Where a specialist assessment was completed it appears not to have been appropriately passed on.

A prevailing orthodoxy in Children's Specialist Services, that if the family was co-operating the safeguarding threshold was not met, prevented a more co-ordinated and systematic assessment of Autumn taking place on several occasions. The lack of focus on perpetrators and the language used to describe Autumn's lived experience obscured the reality of her circumstances, and the sustained and significant harm she was suffering. There was insufficient scrutiny and challenge within and between services which led to failures in co-ordination, communication and insufficient oversight of the decision making and practice in relation to Autumn.

9.2 Understanding, assessing and responding appropriately to Autumn.

Autumn consistently disclosed assaults by her mother. When she was raped by her main groomer in May 2011 she made three separate disclosures to agencies about this incident. Autumn continued to disclose what was happening to her and this is recognised in the chronology. Autumn tended to withdraw allegations once she had made them and this was accepted without further inquiry or engagement with Autumn. This behaviour had undue significance in deciding how to proceed by individuals involved in assessing, inquiring into and investigating allegations of potential harm to Autumn. This in turn led to a view about Autumn and her response to agencies which saw her withdraw further into silence and made her more vulnerable to the power of her abusers:

'A perception that a young person is troublesome, rather than troubled, can affect their credibility and influence whether that young person seeks help. It can also make them fiercely resistant of offers of support. Rejecting help is more likely if the young person feels they have been let down in the past by those who should have been protecting them.

London CSE Operating Protocol (2015) Metropolitan Police

This also coincides with similar conclusions set out in the NSPCC's (2013) online publication of the learning from Serious Case Reviews into CSE:

- Carry out early comprehensive assessments and establish a complete picture through assessment from different agencies.
- Balance a young person's rights with the need to protect.
- Consider the wider context of young people's risk taking behaviour. When dealing with troubled children, practitioners need to see young people as vulnerable children in need of protection rather than focussing on their challenging behaviour.
- Take disclosures seriously. Disclosure from young people of underage sexual activity needs to be taken seriously and dealt with as a crime.

9.3 Links to the findings in 'If Only Someone Had Listened' published by the Children's Commissioner in 2013:

This framework explores *recognition, telling and help* from the viewpoint of the child. The research that led to the development of this framework was used to understand and explore Autumn's journey through services as part of the second learning event. Participants found this helpful in their understanding and analysis of what happened. The framework identifies an issue for young people who have already recognised harm and told someone about it, and where this has led to help or intervention which results in no change in that young person's circumstance:

'Where young people experience dead ends over a period of years they may become less likely to tell and less likely to recognise that they need help. Negative experience of support, including professional intervention earlier in childhood, had an effect on subsequent recognition and telling – a vicious circle which could encourage extreme self-reliance and compound the effects of abuse. Alternatively, young people might receive a sensitive initial response to the sign or symptom which could lead to prompted telling and then to receiving help about the underlying abuse. Sometimes recognition came last, a significant time after receiving help. A positive experience of services encouraged a virtuous circle leading to the young person becoming more likely to tell in the future and also being more likely to recognise and understand harmful situations.'

This framework provides an overview of how recognition and telling was responded to for Autumn, and the focus of help offered.

Using the framework it is possible to demonstrate that Autumn clearly *recognised* the earlier physical harm she had experienced from her mother and had *told* her primary school about it in a *purposeful* way. This had triggered three responses in relation to the *cause of the harm but no sustained help*. It was at this point, from 2007, that Autumn became self-reliant, spending time away from the family home and living at her grandmother's house.

In 2010 her secondary school *partially recognised* that there was a problem and referred Autumn for support. From this point onwards there was recognition of a need to support Autumn and a number of practitioners provided this support to both Autumn and her family. However *this help was focused on support in relation to the symptoms of the harm rather than addressing the causes of the harm.*

Through 2011 and 2012 there are clear examples of Autumn and her family *recognising and telling* about the harm. Initially the *professionals recognised the harm, but focused the help on supporting Autumn and her family to cope with the symptoms of what was happening with little focus on the cause*. They also failed to recognise, understand, assess or respond to clear and significant indicators of harm.

The delay in recognising and responding to the harm suffered by Autumn appears to be related *to the police and Social Care needing Autumn to sustain purposeful telling about the harm she was suffering*. When Autumn withdrew from the original disclosures the services followed suit and often

withdrew help at this point. A lot of work was done to support her disclosing the harm, but there was a delay in responding to the causes of harm and the beginning of gathering evidence of this harm. From November 2011 there was more recognition of the causes of harm and, with the setting up of the CSE Hub, a focus on securing evidence of this harm. The work on *the cause of the harm was not fully integrated into the support for the symptoms of the harm* and this continued until May 2012. At this point there was significant evidence about *the causes of harm and the concerns about the harm then came together*. This resulted in a focused support package to protect Autumn from the causes of harm and Autumn was accommodated by the Local Authority away from Bradford in a residential placement.

From this point *on it was easier to co-ordinate and provide help in relation to both the causes and symptoms of the harm, and for Autumn to be able to tell about the harm in a sustained and purposeful way* which led to the eventual convictions of the majority of the alleged perpetrators.

10. Developments in Bradford after 2012 in relation to CSE:

10.1 Bradford Safeguarding Children Board agreed a seven point strategic response to CSE in July 2013. This was replaced by a nine point strategic response agreed in December 2014. The strands describe statutory safeguarding activity to be undertaken by statutory and voluntary sector partners, awareness and training activity and community activities informed by specific knowledge of the incidence of CSE in the Bradford District.

The overall aims of these strands were to:

- Safeguard and promote the welfare and children and young people who have been, or may be sexually exploited.
- Successfully prosecute those who perpetrate or facilitate CSE.
- Limit the opportunities for potential perpetrators to abuse children and young people in this way.
- Support families and communities who are dealing with the consequences of CSE.
- Develop preventative services which raise awareness of CSE among children and young people, parents and the communities of the district.
- Develop community resilience to the potential divisive and damaging impact of CSE on the Bradford District and its constituent communities.
- Offer support and therapeutic services to survivors of CSE.
- Ensure that identified perpetrators receive a treatment programme in order to minimise the chances of reoffending.
- Ensure that arrangements are in place to undertake any necessary investigations into historic cases of CSE.

<u>The nine point response included the following:</u>

- A partnership response to CSE which is child, young person and victim focused.
- A multi-agency co-located team which will work together to reduce the risk to victims and bring offenders to justice.
- A training plan for all professionals and leaders regarding CSE. In particular a bespoke training programme will be developed for Schools to identify too pupils and teachers, the signs of being groomed for CSE.
- A plan will be developed for all faith and community leaders to support communities through the damage caused by CSE.
- A support network focusing on women and mothers of perpetrators.
- A specific direct work plan aimed at boys between 14 and 17 years to tackle any unacceptable attitudes regarding the sexual abuse of any person.

- A specific product for the Pakistani origin community which addresses CSE and explores the harm that this offence can cause to individuals and families.
- A partnership response to reduce the opportunities for perpetrators of CSE to traffic and abuse children and young people, through the use of all regulatory functions of the Council and its Partners.
- A partnership response to include undertaking multi agency historic investigations into CSE.

Further BSCB developments of scrutiny and challenge

- The introduction of CSE challenge panels.
- The development of a CSE improvement plan
- The introduction of CSE case audits
- The review of the CSE Hub

10.2 Highlighting good practice – key findings:

10.2.1 School and other Education provision

Autumn's school provided consistent support to her during 2011 to try and keep her engaged in school. Autumn appreciated the support of the learning mentors and the school counsellor. The school secured Autumn a place in a local pupil referral unit when it became impossible to contain her in school.

When she returned to school following her time in the PRU, the school struggled to cope with and contain her. They did support securing additional placements for her in other provisions and were consistently involved in the Child in Need meetings and in making representations about her safety and welfare.

The PRU made a positive contribution to re-engaging Autumn in education supporting her progress and development. Autumn benefitted from the commissioning and provision of a smaller education unit whilst she was in her residential placement.

10.2.2 Health Services

The BDCFT - CAMHs provided a thoughtful and supportive intervention to Autumn and her grandmother to explore Autumn's experience of the dynamic between herself and her mother.

At the consultation with her GP, when Autumn disclosed her rape, the response was inadequate. At a later consultation with a different doctor, the GP was supportive and took time to see Autumn on her own.

The consultation with sexual health services was the only time Autumn's sexual health needs were considered and Autumn's sexual health was assessed.

10.2.3 West Yorkshire Police

There was a change of leadership and focus in early 2012, following on from the Local Safeguarding Children Board Challenge meeting in November 2011. The police were key figures in establishing the CSE Hub in January 2012. They stepped up their criminal and forensic investigation and also made attempts to engage Children's Specialist Services in conversations about the need to secure Autumn's protection including taking her into Police Protection.

Some missing incidents were responded to well,

Autumn and her family report some positive relationships and experiences with individual officers and those who took the missing reports. The family were appreciative of the local police response to them and the support given to Autumn when she returned from missing episodes.

The police led the co-ordination of the investigation and support to Autumn in the residential placement, through an extended Gold command, along with the local Looked After Reviews. They secured successful prosecutions and convictions of the perpetrators and provided on-going support for the family.

The police have transformed their response to CSE and it is now the top strategic priority. Significant investment and training has taken place and partnership working has been considerably enhanced.

10.2.4 Children's Specialist Services

Autumn had a consistent community resource worker from May 2011 to May 2012 who chaired the Children in Need meetings and co-ordinated family support and other services to seek to retain Autumn within her family network.

The placement support service provided to Autumn over the summer of 2011 was successful in that Autumn did not go missing from this provision and that they were able to offer a consistent service.

Funding was secured to support the residential placement. Family contact with Autumn in the placement was also supported, co-ordinated and supervised where required. Contact was maintained with Autumn in her residential placement and she continues to receive leaving care support.

10.2.5 Access and inclusion: Education Social Work

Education Social Work staff were involved in transporting Autumn to the PRU on occasion and they did attend the BAC meetings and review progress within the PRU.

10.2.6 The Children's Society

Consistent attempts were made to engage with Autumn in her home community and to support her with the transition to her residential placement. There were attempts put in place for a planned programme of work. Autumn was not always in a position to take up this support.

10.2.7 Barnardos

Barnardos assessed Autumn as at high risk of CSE following her referral to the Turnaround Project in the Summer of 2010. This was passed onto the local CSE support service. Barnardos provided a structured programme of individual support to Autumn whilst she was placed in the residential unit.

10.2.8 PACE

PACE began to provide support to Autumn's grandmother in April 2012 and this support carried on through Autumn's residential placement and the trial.

10.2.9 CAFCASS

CAFCASS provided Autumn with a Children's Guardian as part of the care proceedings during 2014. They supported Autumn's application for no order to be made.

10.2.10 Residential Unit

Autumn was placed in the residential unit on in June 2012. The unit was able to provide a safe space for Autumn and to assist her to provide witness statements and interviews to the Police. They enabled her to access Education and to develop in other ways. They promoted contact with her family and worked with Autumn to help to keep herself safe. They co-ordinated and provided a range of other opportunities for Autumn.

11. Conclusions in relation to the terms of reference

11.1 A description of Autumn's journey:

What becomes apparent over the course of Autumn's journey is the combination of factors in her own development, family context and community environment which contrived to create a particular vulnerability. This picture was not put together in any assessment process at the time.

11.2 A description and analysis of Autumn's emotional state and response to her experiences as well as her behavioural reactions and her level of understanding and functioning:

Autumn states that her early life had taught her that she could not trust or rely on her mother or the responsible services to protect her from the harm she was experiencing. This was further compounded by her experience of the grooming process which resulted in her abuse and exploitation. This made it difficult for workers to engage successfully with Autumn and make meaningful relationships. This was a common feature of the conversations about working with Autumn as part of the first learning event.

Her mother's attachment to Autumn was assessed by CAMHS as avoidant and that this contributed to Autumn's feelings of rejection and isolation. The panel spent time exploring the impact of this attachment on Autumn. The panel looked at it in relation to the harm and neglect Autumn was subject to, her eventual abandonment by and temporary estrangement from her mother and the support, concern and commitment often displayed by her mother about what was happening to her daughter.

Catlett (2015) describes avoidant caregivers as having 'a more limited repertoire of care giving strategies at their disposal'. She describes parents of children with an avoidant attachment as tending to be emotionally unavailable or unresponsive to them a good deal of the time. They tend to disregard or ignore their children's needs and can be especially rejecting when a child is hurt or sick. This pattern is identified as occurring in around 30% of the population. Rholes et al (2006) also pointed out that 'avoidant adults do provide care to others, including their children, at times, but they often do so to meet social obligations or to receive favours rather than due to feelings of love and concern, and the help they provide is often given from a safe emotional distance'. This may explain why Autumn's family were able to provide support to Autumn in her residential placement.

The impact on the child is that they learn to rely heavily on self-soothing, self-nurturing behaviours in trying to cope with the pain of being rejected. They develop a pseudo-independent orientation to life and maintain the illusion that they can take complete care of themselves. As a result they have little desire to seek out other people for help and support. Autumn still feels a lot of anger towards her mother in relation to the rejections she experienced. This avoidant attachment by her mother may also partially explain worker's experiences of Autumn as independent and hard to engage.

Autumn's enuresis contributed to making it hard for Autumn to make peer friendships and she was vulnerable to exploitation as a result of this. There is no evidence that Autumn had material

rewards as part of the grooming process. The participants at the learning event felt that Autumn had a real need for love and friendship and this was what was exploited during the grooming process and the abuse. Autumn also took on a number of different identities in social media and also adopted some aspects of Pakistani language and dress as she grew up.

Research identifies that victims are often understood and assessed through their behavioural presentation and this is clear in Autumn's case. There are numerous references to Autumn's behaviour in the chronology and very little curiosity as to what was driving this behaviour or what was happening to her as a result of it. This is particularly clear in her early episodes of going missing and in the response to key missed opportunities which are already referred to.

As the abuse escalated Autumn was coerced and kept in the abuse through threats to her family. Autumn states that she was compelled to continue in order to keep her family, and in particular her sister, safe. These threats were credible. Her family were verbally abused and threatened in the street, additional security was placed in the family homes and her uncle was subject to a serious assault following the recovery of evidence from a laptop. As this escalated through the spring of 2012 it became impossible for Autumn to contain the threat to herself. For the first time Autumn disclosed something of what was happening to her, to others. This, along with emerging forensic evidence, resulted in active steps being taken to protect her.

Consistent concerns have been expressed about Autumn's psychological state, her exposure to trauma, her resilience and her recovery from all of her abusive experiences. It is clear that when Autumn was placed in a safe and nurturing environment, where she was free from the threat of harm, she was able to make use of this to settle, grow, develop and achieve. There is some research evidence in the literature on trauma to suggest that self-soothing activities such as contact with horses has a neurological impact on easing and resolving trauma, rather than the more traditional approach of using talk therapies.

11.3 A description and analysis of issues of culture, ethnicity and identity within the immediate family and local community:

The findings indicate that a contextual view of Autumn's and her family's place in her community was not considered as part of any assessment and are covered in more detail in an earlier section of the report. What further becomes apparent is the confusion over boundaries, roles and responsibilities and the impact this had for agencies in their assessment of Autumn in terms of her identity and culture and the risks she faced. This made it hard for workers to make a meaningful connection and relationship with her between 2010 and 2012.

11.4 The ways in which organisations worked with the subject and her family and with each other:

The findings indicate, that although there was no lack of commitment and willingness on the part of individual workers and agencies to work with Autumn and her family. This was taking place between 2010 and 2012 without a clear assessment and with the wrong focus. This was taking place within a strategic and procedural framework which was unclear and confused, and which was poorly understood by the individuals involved with Autumn and their managers. As has already been identified, there were also occasions when the existing procedures were not followed and this led directly to systemic failure.

The West Yorkshire Police revised their priorities, reaction and response to child sexual exploitation in early 2012 and led the drive to create a CSE Hub. This created conflict with Children's Specialist Services who continued to pursue an approach based on a belief about the need to support families and to work with CSE outside of a formal safeguarding framework. Thus, applying a 'Child in Need' framework to most cases where there were CSE concerns. The dynamic review was established to confront these issues and this contributed to the development of a working relationship based on a shared understanding and a common approach between WYP and Children's Specialist Services.

The wider health community has been marginal to Autumn's case, despite a number of interventions in primary care, CAMHS and sexual health services. It appears that Autumn was lost to health scrutiny in relation to her enuresis and physical health, and that she wasn't known to paediatricians as other vulnerable young people in the area were. The school nursing engagement with other agencies was disrupted and then lost. As both Anne Coffey (2014) and Barnardos (2014) point out in their respective reports there is a significant impact on the physical and mental health of children and young people who are sexually exploited which needs to be addressed.

Education social work also failed to intervene to support Autumn, her family and the school even though her attendance declined to 40%. The role of education social work was described as focusing more on implementing and administering parental fines for nonattendance. This does not appear to have been the best use of this resource in relation to CSE.

The local CSE support service attempted to keep and maintain a relationship with Autumn and her family. This was described by Autumn and her family as not having much purpose or focus – 'they would just take me to McDonalds'. The local CSE support service do not seem to have communicated their concerns effectively with Children's Specialist Services or kept sufficiently detailed records.

There were a series of meetings held between June 2011 and May 2012 which attempted to bring key participants together to co-ordinate information, assessments and plan actions. Autumn's mother, stepfather and grandmother were involved in some of these meetings but Autumn was not. The participants kept an inappropriate Child in Need frame around the work even when concerns were escalating. The participants were often unaware of important developments which had taken place between meetings.

From January 2012 the police allocated more resources to Autumn's investigation and adapted a more forensic approach. The police involved Autumn's family in the gathering of intelligence and evidence. Officers from the Homicide and Major Enquiry Team were allocated to the case and the police stepped up the level of their concern. This culminated with taking Autumn into Police Protection. When Autumn was accommodated away from the Bradford area the police undertook a co-ordinated programme of interviews and support with the residential unit, with Children's Specialist Services and with Autumn's family. This eventually led to successful prosecutions.

The delivery and co-ordination of care and support provided by the residential unit with the support of other agencies was good. This has made a major contribution to the outcomes achieved by Autumn over this period of her care, along with assistance from other partners and Autumn's family. The care offered corresponded closely to the key messages in the safe accommodation briefing paper published by Barnardos in 2011.

11.5 Current issues and developments in relation to child sexual exploitation. In particular whether there is any denial in agencies and organisations in relation to identifying and intervening into situations of CSE. In addition the effectiveness of current safeguarding practice and the range of interventions:

Using the current information supplied to the review, no evidence has come to light of a culture of denial in relation to the leadership and governance of organisation and agencies in Bradford, as identified in Rotherham by the Casey report. This finding is supported by the on-going developments in Bradford since 2012 in relation to CSE, and by the report from the Strategic Director of Children's Services to the Council Executive in September 2015 (see appendix 6). CSE is now the top priority for West Yorkshire Police and significant investments have been made in both staffing and training which have transformed the police approach to CSE in Bradford in comparison to the position in 2011.

The Bradford Safeguarding Children Board has played a proactive role on leading, shaping and directing the response in the District and there has been a co-ordinated response by key strategic leaders working through the Board to develop services and practices. This can be clearly seen in the agreement of strategic principles and approaches to CSE in the 9 Point Plan and in the

development of the CSE Hub. The Board has maintained a dynamic approach to the development of services and has kept a focus on this area of practice, running two challenge events and a major conference.

Bradford has continued to respond to the challenge of CSE with a range of developments and initiatives. This has included the provision of generic and specific multi-agency training for professionals, along with comprehensive awareness training. Two reviews leading to further developments within the CSE Hub have included a significant reallocation of resources to the service. West Yorkshire Police, in particular have transformed their strategic response investment and approach to CSE. There have been a range of community developments and community engagements in relation to CSE, including community based awareness-raising across the district and within the community in which Autumn lived.

Action to improve and develop procedure and practice along with urgent remedial action where necessary, has been taken as this review has progressed. A further review of the CSE Hub has been commissioned and this incorporates concerns identified both from Autumn's journey and from the learning events held, to assess how best to develop services in the light of current experience.

The Partnership learning framework has highlighted a need for practitioners to be encouraged to display more professional curiosity in relation to situations where there is a concern about CSE. Further, to demonstrate more curiosity about the circumstances of the lives of vulnerable children and include a professional judgement in their assessments of harm. In addition agency leaders and managers should be more proactive in seeking assurances and actual evidence that practice has changed. In this context, the December 2015 independent audit of cases referred to the CSE Hub was welcome.

The terms of reference of the Partnership Learning Review were extended to support the authors' understanding of the community within which Autumn grew up. As a result of this the author was briefed on some of the excellent community development and support work being undertaken in that area to help to frame a broad community response to the issue of CSE. The review has also been informed of a wider dispersal and use of interventions, and new statutory powers which indicate a broader response to intervening and disrupting CSE. The current review of the CSE Hub is looking at developing, co-ordinating and integrating these responses.

The scope and focus of the review has been broad and wide ranging. In addition to the individual agency action plans and the recommendations contained in this review, further work by the Panel and Author has resulted in other developments as the review has progressed. These include:

- Getting a better understanding of the relationship between enuresis, family stress and harm.
- Clarifying the definitions of gang based and group based harm in relation to CSE, within the context of CSE and Police definition of gangs.
- Clarifying our understanding of avoidant attachment in parenting and its impact on children and young people.
- Clarifying with the Safeguarding Children Board the position of meetings and assessments in relation to CSE within mainstream safeguarding procedures and processes.
- Reviewing the provision of legal services to Children's Specialist Services.
- Reviewing the complexities of consent in relation to social pressures experienced by children (Pearce2013, Coy et al 2013 and Firmin 2013): Fraser competency and safeguarding boundaries in delivering sexual health services to young people, and clarifying with the current provider how practitioners are supported to make assessments and decisions, record and seek support and advice in relation to this complex area of practice.

12. Themes arising from within the learning the review:

12.1 Assessment and intervention into enuresis:

Enuresis incontinence and wetting are all terms used for children who have problems with controlling the passing of urine. All three terms can be used interchangeably but are usually used in different contexts. Enuresis can be nocturnal (i.e. bed wetting) or diurnal – includes day time wetting. Incontinence can apply to bed wetting but is usually used for day time wetting. The enuresis, incontinence or wetting may be primary (has always wet the bed and never been fully dry at night) - or secondary - (dry for a period of time). Primary Nocturnal Enuresis is the term usually used for bedwetting.

"A typical child with bedwetting (nocturnal enuresis) is a 7-8 year old boy with primary enuresis) often with a family history (dad / uncle) who had the same, and has no indicators for other causes (e.g. symptoms of infection, or other medical causes. The nocturnal enuresis in this case is usually due to genetic delay in maturation of the hormones involved. Whilst there may be mild elements of stress or psychological issue which may exacerbate this, the child usually responds well to basic measures." (Designated doctor – Safeguarding)

Autumn's was a very different presentation. She was female, older, and had secondary nocturnal enuresis and daytime wetting and soiling. She may have had a kidney problem too. Thus she is atypical in every aspect and had a number of flags for social issues, child protection concerns and stress. In Autumn's case the wetting was much more likely to be due to social and psychological factors including abuse.

Faecal soiling or encopresis refers to passing stools inappropriately. This may be a mild staining of the pants through to passing whole stools and smearing the faeces/stools. Faecal soiling or encopresis is a more concerning sign. Young Children can soil if they are constipated. This can also cause exacerbation of any bed or day time wetting. However deliberate soiling or soiling in an older girl (11-12 years of age) is again much more likely to be associated with significant social/psychological factors including abuse.

Additional recommendations are made in this Review in relation to assessment and intervention in responding to enuresis in children.

12.2 Using the Children's Commissioner's framework for recognition, telling and help to understand the interventions whist Autumn was living in her home town:

The framework for understanding recognition telling and help developed from research supported by the Children's Commissioner in 2013- 'It takes a lot to build trust' has been helpfully applied to Autumn's circumstances and has assisted us in understanding the framing of Autumn's journey. This research was recommended to us by Professor Jenny Pearce, the expert adviser to the panel. This Review recommends a wider adoption of this framework as a way of understanding and developing earlier routes to appropriate help for children.

The experience of using this framework at the second learning event enabled practitioners to understand how service and professional responses to Autumn were partial in their focus, and missed a full contextual analysis of Autumn's experiences and the risk of harm she was suffering. The framework made it possible to see that the services around Autumn only had a partial recognition of what was happening to her and some had no recognition. This was despite Autumn telling people consistently about the harm she was suffering both indirectly through family and directly to a number of professionals. For Children's Specialist Services this was a lot later than for police and school as their focus of help remained for far longer on supporting Autumn within her family network.

12.3 The Local Safeguarding Children Board and Assurance in relation to thresholds and meetings:

There is currently reason for the Bradford Safeguarding Children Board to seek assurance as to the shared understanding and robustness of the processes for ensuring that CSE risks are addressed. That these risks are assessed in a timely and effective manner within a framework of

proactive safeguarding and child protection. These issues were identified as a continuing area of concern at the second learning event in February 2016.

It is of particular importance that the Board is assured that professionals, services and organisations understand the processes for engaging with CSE, including the expectations around which assessments need to be undertaken. Further, that there is agreement over the threshold levels to be worked at, and the status of meetings to be called. This must include identifying who is required to attended, in order to implement plans and support and review interventions.

12.4 Further development of the CSE Hub:

The first learning event identified the need, and proposed that there should be a further development of the integration of partners into the CSE Hub. This is to enable health and education partners to fully engage in the activity of the CSE Hub. The second learning event contributed to this discussion and a further review of the work of the CSE Hub was established in December 2015, partly in response to this Serious Case Review.

Key leaders, and those involved in the CSE Hub review met early in the New Year and presented options to the CSE and Missing Sub Group of the Board. The Panel received an update of progress in April 2016 in relation to areas of concern identified through the second learning event. . In May 2016 a report was presented to the CSE and missing group on the progress of the review, a framework for working with CSE and on how best to achieve a better integration between the work of the CSE Hub and the work being taken forward locally.

During the interviews with key personnel in Autumn's home town, it became clear to the review that there was a disconnect between the work of the CSE Hub and the work being undertaken and developed locally. It was also understood from further discussions that it was not a straightforward matter to identify the best way of coordinating the work streams and bringing them together.

An external case file audit of children referred to the CSE Hub, identified as at high and medium risk of sexual exploitation, was undertaken in December 2015.

Concerns have been raised during the interviews, and to the review panel, about the current status and functioning of the Forensic and Medical Assessment Services within West Yorkshire. Given that this is one of the key mechanisms for ensuring that victims of CSE get access to a full medical assessment, and the recovery and preservation of a range of forensic evidence, the Board should ensure that this situation is reviewed and any appropriate action undertaken.

12.5 Further development of Early Help and Family Support Services:

The Review Panel and the learning events have raised concern about the safe integration of CSE support work within an early help framework, including how assessments and support work can be effectively integrated within robust safeguarding frameworks.

12.6 Further development of work with perpetrators:

Both the review panel and participants at the second learning event have raised concerns about the progress and development of previously agreed work by the Board, to develop a strategy in relation to work and interventions with perpetrators which include a preventive and a restorative approach.

12.7 Supporting a culture change around the language, focus and understanding of everyday safeguarding activity in relation to CSE:

The review has identified that CSE creates a challenge to orthodox safeguarding and child protection practice. The challenge is that the primary focus of the risk assessment is not within

the immediate family, and the primary focus of decision making is not the extent to which the family is engaged. This point was clearly made in the CEOP report 'Out of Sight, Out of Mind (2013)

Safeguarding systems need to integrate much more with disruption and other activities which have an impact on offenders. They have to create a much more effective online presence and engagement with children and young people.

It is also clear that some of the community development work and community responses being developed in Autumn's home town form part of a broader approach to safeguarding. Ways should be found to incorporate this work into a broader remit and understanding of safeguarding interventions. This is being looked at as part of the current review of the CSE Hub.

13 Recommendations arising from the serious case review are:

13.1 For the Bradford Safeguarding Children Board:

I. That the BSCB carry out a programme to communicate a shared understanding of the risks and challenges of CSE
II. That the BSCB carry out a programme of audits to ensure that assessments, threshold levels and safeguarding meetings meet the expectations set out in the multi-agency safeguarding procedures on CSE.
III. That the BSCB ensures that a report on the need for therapeutic services for the victims of CSE is presented to the Health and Wellbeing Board.
IV. That the BSCB ensures that immediate action is taken to ensure that all agencies and partner organisations understand their accountability for the safeguarding of children through the rigorous sharing of all relevant information.
V. That the BSCB ensures that the Information Sharing Guidance is cascaded down through all services working with children and their families.
VI. That the BSCB ensures that all staff working with children at risk of CSE are given training on the use of the risk assessment framework and what constitutes an effective referral to the CSE Hub.

13.2 For the review of the CSE Hub:

The key areas identified in this report which will be addressed as part of the CSE Hub review process are:

I. The further co-ordination, development and integration of CSE services, into the family support and early help offer to children and their families.
II. Further strategic development in relation to working with perpetrators.
III. The CSE hub seeks additional investment of time and staff to support the co-ordination and engagement of the wider health community and education services in the activity of the hub and in the wider safeguarding activity in relation to CSE.
IV. Continuing to support and develop a culture change around the language, focus and understanding of everyday safeguarding activity in relation to CSE.
V. Supporting further community development and community engagement in activities to address CSE.

13.3 For the review of the CSE forensic and medical assessment services in Bradford.

I. That the Board assure itself that the work and operation of the Forensic and Medical Assessment Services in West Yorkshire supports needs of victims of sexual assault in Bradford, as part of the operation of the CSE Hub and more widely.

13.4 For further work to integrate a range of perpetrator programmes, not covered by the review of the Hub, within a broader CSE strategy

To ensure that work with perpetrators, which falls outside the current remit of the work stream in the CSE Hub review, be included in the development of a broader strategy of prevention and disruption of CSE. These should include:

I. To ensure that work is carried out to respond to young people on 'sexually harmful behaviour'
II. That prevention and restorative work is undertaken
III. That other strategies on therapeutic work is taking place
IV. That there is clarity about the nature and range of interventions undertaken by the Probation Service.

13.5 The adoption of the Children's Commissioner framework in relation to recognition, telling and help - for assessment, audit and analysis purposes:

Consideration should be given to the adoption of this framework for:

I. The training of front line staff on working with children suffering or are at risk of CSE.
II. To improve the quality of analysis and professional judgement when carrying out an assessment of a child suffering or at risk of CSE.
III. For audit and analysis purposes.

13.6 Understanding the impact on a child in relation to enuresis and soiling:

I. That where relevant, issues of enuresis and soiling are routinely included in assessments about vulnerability and harm.
II. The causes of enuresis and soiling are routinely assessed in the context of stress and social impact as well as consideration of physical causations.
III. That a multi-agency pathway be developed to support the diagnosis and treatment for enuresis and soiling, and the assessments which safeguard children in these circumstances.
IV. That an appropriate training package is sourced for front line practitioners to give guidance and promote understanding of the issues and impacts of enuresis and soiling on children.
V. To assess the level of parental nonattendance at clinics or other appointments and what could be done about this to ensure that children and young people receive the treatment, intervention and support they need in a timely and effective way.
VI. That an audit of CIN and CP cases involving children with enuresis and soiling is undertaken. This audit would ascertain whether issues of enuresis and soiling have been appropriately factored into assessments and plans and the issues understood from the perspective of the impact on the child.

Please note: The action plan arising from the recommendations is organised around the Key themes resulting from the Key findings within the report. The link between the recommendations and each area of the action plan is identified through the action point numbered within section 13.

13.7. Conclusion:

The review can conclude, from the information provided from the range of strategic and operational activities connected to local leadership and governance, that whilst challenges remain and persist, significant progress has been made. This includes addressing any denial, lack of understanding and awareness at a number of levels, including at the strategic leadership level. This conclusion is dependent on the pending agreement to and implementation of the action plans identified as part of this process. There is on-going commitment to taking forward work to further develop the response to CSE within the prevailing policy and resource environment in the Bradford District, including the recommendations and findings of this Review

14 References:

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Rholes, WS Simpson, JA and Friedman M (2006) Avoidant Attachment and the Experience of Parenting PSBP Vol 32 No3 pp275-285

University of Bedfordshire (2011) What's going on to safeguarding children from sexual exploitation? Sue Jago and Professor Jenny Pearce

University of Bedfordshire (2011) Safe accommodation for sexually exploited and trafficked young people. Briefing paper Dr. Lucie Shuker

University of Bedfordshire (2013) It's wrong… but you get used to it. University of Bedford, Beckett et al

University of Bedfordshire (2015) Families and Communities Against Child Sexual Exploitation, final report. Dr. Kate D'Aray et al

15 Glossary of terms:

ACReS	Adolescent Crisis Resource Service
BACS	Behaviour and Attendance Collaborative: Formed by Bradford Secondary Schools in 2007 and linked to geographical areas in the district. Meets weekly with Schools, Police and Education reps to seek solution focused ways of addressing the needs of complex children and young people.
BSCB	Bradford Safeguarding Children Board
BDFCT	Bradford District Care Foundation Trust
BMDC	Bradford Metropolitan District Council
CCG	Clinical Commissioning Group responsible for arranging a lot of local Health care provision.
CSE	Child Sexual Exploitation
CEOP	Child Exploitation and Online Protection Centre
CROP	Coalition for the Removal of Pimping. Was a CSE family support charity. The pre-cursor to Parents Against Child sexual Exploitation. See below
DCSF	Department for Children, Schools and Families
DfE	Department for Education
ESH	Education Safeguarding Hub: This multi-agency hub was set up in April 2016 and has representatives from Education, Police and Health working together to identify children missing education
GMC	General Medical Council
HMET	Homicide and Major Enquiry Team
IAR	Independent Agency Review. The report produced by an agency by an author independent of the case which summarises, analyses the involvement of the agency, identifies learning and proposes action
LSCB	Local Safeguarding Children Board
MAACSE	Multi Agency Action on Child Sexual Exploitation. A monthly meeting of LSCB Partners and the Voluntary Sector to review individual cases and co-ordinate action.
PACE	Parents Against Child sexual Exploitation. A CSE support group for parents and family members-previously known as CROP see above.
Partnership Learning Review	A collaborative inquiry based approach to Serious Case Reviews with a focus on shared learning and development of safeguarding systems.
PPR	Person or People Posing a risk to Children. The terms 'Schedule One Offender' and 'Schedule One Offence' have been commonly used for anyone convicted of an offence against a child listed in Schedule One of the Children and Young Persons Act 1933. However, a conviction for an offence in Schedule One does not trigger any statutory requirement in relation to child protection issues; inclusion within the definition of Schedule One Offender was determined solely by the age of the victim and the offence for which the offender was sentenced, and not by an assessment of future risk of harm to children. For this reason, the terms Schedule One offence and Schedule One Offender are no longer used and have been replaced by references to Risk to Children Offenders. This clearly indicates that the person has been identified as presenting a risk, or potential risk, to children. Bradford Safeguarding Board Child Protection Procedures.
RCPCH	Royal College of Paediatrics and Child Health

16 Appendices:

- **Appendix 1: Link to the full PLR for carrying out SCRs:** http://www.dorsetlscb.co.uk/site/wp-content/uploads/2009/12/Partnership-Learning-Model-A-Model-for-Conducting-Serious-Case-Reviews.pdf

- Appendix 2: Link to the Report from the Strategic Director of Children's Services to the Council Executive 15th September 2015: http://democracy.bradford.gov.uk/documents/s4862/Exec15SeptDocQ.pdf

- **Appendix 3: Link to the Children's Commissioner report 'It takes a lot to build trust': summary version:** http://www.childrenscommissioner.gov.uk/sites/default/files/publications/It_takes_a_lot_to_build_trust_FINAL_REPORT.pdf

- **Appendix 4: An overview of key research and policy documents as they relate to findings in relation to Autumn:**

- **Safeguarding children and young people from sexual exploitation: Supplementary guide to Working Together to Safeguard Children DCSF 2009:**

    - The guidance also sets out how to manage individual cases and discuss the timing and process of referrals to Children's Specialist Services and initial assessment under the Children Act 1989.

- **Out of Sight, Out of Mind CEOP Thematic Assessment June 2011:**

    - CEOP published this thematic assessment to "increase people's understanding of this appalling crime":

- **Safe accommodation for sexually exploited and trafficked young people: Briefing paper University of Bedford July 2011:**

    - The report highlights research which suggests that the proactive arrangement of services makes a placement more likely to succeed. It is reported that young people particularly value services which 'recognise the importance of Education, training and employment, their Health needs and the links they have with families and carers'.

    - The briefing paper also notes that 'despite the high levels of security used as part of a child's safety plan, traffickers regularly find ways to make contact'. Nevertheless a combination of secure arrangements and intensive therapeutic care can enable adults to engage effectively and build trust with young people in order to reduce 'missing' incidents.

- **The Independent Inquiry into Child sexual Exploitation in Rotherham. Professor Alexis Jay 2013:**

- In just over a third of cases, children affected by CSE were previously known to services because of child protection and neglect. The victims suffered appalling abuse which included rape by multiple perpetrators.
- Following a failure to respond to these concerns outlined in the report Louise Casey was directed to lead an inspection into Rotherham Borough Council.

- **What's going on to Safeguard Children and Young People from Sexual Exploitation? University of Bedfordshire October 2011:**

    - A key finding was that LSCB's were failing to safeguard young people from sexual exploitation and that three quarters of LSCB were not proactive in implementing the 2009 guidance. Co-located units were seen as an 'ideal type' for implementing this strategy and only 10% of the areas which took part had such a unit in place.
    - The report proposes that each LSCB area have a co-ordinator, that training and awareness programmes are implemented and that each area have a co-located team.

- **Tackling Child Sexual Exploitation: Action Plan 2011:**

    - Bradford District's response was summarised in the Partnership Response to Child Sexual Exploitation published by the Safeguarding Children Board in May 2012 and Autumn was a key focus in framing this response.
    - This document had its origins on the challenge and briefing days Chaired by the Independent Chair of the Safeguarding Children Board in May and November 2011.

- **It's wrong… but you get used to it: University of Bedfordshire 2013:**

    - Young women's exposure to risk varies according to their status. 'Links' (young women associated through 'casual' sex with one or more members of the gang) were the group most at risk of sexual victimisation both within the gang and from rival groups.
    - Young women were very frequently blamed for the harm they experience:

- **If Only Someone Had Listened 2013 Children's Commissioner, Sue Berelowitz et al:**

    - This report identified nine significant failings in the then current response to CSE:

- **Child Sexual Exploitation: Learning from Case Reviews NSPCC 2013: Online digital briefing. Learning for improving practice:**

    - Consider the child protection implications of underage sexual activity. Professionals providing sexual Health services (including contraception) should consider the child protection implications of possible abuse or exploitation whenever they become aware of underage sexual activity.
    - Carry out early comprehensive assessments and establish a complete picture through assessment from different agencies.
    - Balance a young person's rights with the need to protect.
    - Consider the wider context of young people's risk taking behaviour. When dealing with troubled children, practitioners need to see young people as vulnerable children in need of protection rather than focussing on their challenging behaviour.
    - Take disclosures seriously. Disclosure from young people of underage sexual activity needs to be taken seriously and dealt with as a crime.

- **The Sexual Exploitation of Children: It couldn't happen here could it? OFSTED Thematic Inspection 2014:**

- ‘Until very recently child sexual exploitation has not been treated as the priority it should have been. As a result, local arrangements to tackle the problem are often insufficiently developed and the leadership required in this crucial area of child protection work is frequently lacking. ‘
- ‘Indeed as our findings show, part of the problem lies in the fact that some professionals have simply failed to properly apply child protection procedures and processes to young people at risk of being sexually exploited.’
- ‘In those authorities where child sexual exploitation has had a higher priority the local strategy is better developed with links to other key strategies relating to issues like gangs, licensing and how personal Health and social Education is being taught in Schools. Senior leaders and politicians tend to have greater insight and understanding of this complex issue in areas where this has been given greater priority.’

- **Real voices: Child Sexual Exploitation in Greater Manchester: 2014 Anne Coffey MP:**

    - CSE has a massive effect on the physical and mental Health of children and should be declared a public Health priority issue in much the same way as alcohol, drug taking and obesity.

- **Health impact of sexual exploitation on adolescents. 2014 Barnardos briefing paper:**

    - “The reasons for prioritising the prevention of CSE, identifying children who are being harmed early and developing good quality recovery services are because sexual abuse is a leading cause of PTSD in children. PTSD diminishes their ability to integrate sensory, emotive and cognitive information into a coherent framework.”

- **Tackling Child Sexual Exploitation, Cabinet Office 2015:**

    - The Government’s response to the Jay and Casey report focused on:
    - Eradicating the culture of denial.
    - Strengthening accountability in relation to leadership including the role of LSCB’s.
    - Strengthening joint working and information sharing arrangements.
    - Providing additional support to enable Health service and medical professionals spot the signs early and share information with others.
    - Enhancing whistle blowing arrangements.
    - Focusing on improving the frontline social care response.
    - Stopping offenders.
    - Supporting victims and survivors