Response to Fenestra Serious Case Review by Somerset Safeguarding Children Board (SSCB)

The SSCB commissioned the Serious Case Review 'Fenestra' following notification from the police to the SSCB in late 2015, of nine children who were victims of child sexual exploitation (CSE) by two men who were identified through the 'Operation Fenestra' police investigation.

The offences against the children occurred between 2010 and 2014 in Somerset and resulted in the prosecution and conviction (in November 2016) of the two men for sexual offences against six victims aged between 14 and 15 when the crimes were committed, and a 7th victim aged 18. The men received a total of 32 years imprisonment.

The SSCB Independent Chair in 2015 agreed that the criteria for a serious case review (SCR) had been met because of the significant harm that had been caused to two of the child victims, Child C and Child Q. Both children had experienced persistent sexual, physical and emotional abuse which resulted in serious mental health problems, including suicide attempts. In addition, both children had several pregnancies, ending in miscarriage and termination, prior to both having a child by one of the perpetrators. One child suffered from sexually transmitted diseases.

This SCR focuses upon the exploitation and sexual abuse of the two child victims, Child C and Child Q. The review also recognises learning from the experiences of the other seven young women who were identified during Operation Fenestra, who were also sexually abused by the perpetrators when they were children. Whilst no child died as a result of the abuse they suffered, they have nevertheless been severely affected by what has happened to them.

SSCB has been extremely grateful for the consent of three of the young women and the parents of one to help us with this review, to contribute their thoughts and reflections, and help us fully understand what happened in order that we might be better informed in preventing such exploitation in the future.

The concerns date back to 2010 and 2011, when both children were aged 15 and agencies learned that they had an ‘older boyfriend'. The actual age and identity of any boyfriend was not known initially. There were also allegations that the premises where the perpetrators worked was a location for men to have sex with under-age girls. The police investigation initially commenced in 2012 and then intensified in 2014 due to concerns and allegations reported to statutory agencies in relation to both children. In 2015, once the perpetrators were arrested and charged, the investigation was managed via a multi-agency approach.

Because this case concerned abuse prior to 2014, it was recognised that it was likely to duplicate some of the learning from the Bristol Safeguarding Children Board ‘Operation Brooke’ Serious Case Review (published in March 2016), as well as Ofsted’s inspection of Somerset Children’s Services in 2013 and the various other reports and reviews about CSE which had been published across the country. In order to provide current learning for Somerset, it was agreed initially that the focus should be on recent practice, particularly after Operation Fenestra became more intensive in August 2014. However, it became clear that there was specific learning emerging from earlier periods which it would be important to capture. Therefore, the review period was extended to consider the period from 2009 up until 2014 during which the abuse took place.

The need to await the outcome of the criminal proceedings (November 2016) and then a subsequent appeal against sentence by one of the perpetrators (October 2017) created unavoidable delay to completion and publication of the review.

The scope of the serious case review aimed to identify the strengths and gaps in multi-agency responses to child sexual exploitation, in particular to the 'inappropriate relationship' model of CSE (Barnardo’s 2011: *Puppet on a string The urgent need to cut children free from sexual exploitation*).

The type of CSE suffered by children C and Q is known as an ''inappropriate relationship” model. This is defined as: ***'Usually involving one perpetrator who has inappropriate power or control over a young person (physical, emotional or financial). One indicator may be a significant age gap. The young person may believe they are in a loving relationship'.***

Both C and Q believed they were 'in love' and that perpetrator A was their boyfriend, who gave them presents and intended to have a permanent relationship with them. He was significantly older than them and subjected them to physical, sexual and emotional abuse as part of a controlling relationship.

The review has involved the independent lead reviewer, Edi Carmi, who led the Operation

Brooke SCR in Bristol, and who worked closely with the independent SCR panel chair, Lucy Watson, and a panel of senior managers, including the SSCB Business Manager. The panel was responsible for ensuring that the review process was well planned and managed, Panel members took responsibility for facilitating the provision of agency information and working with the lead reviewer to involve practitioners, reflect on practice historically and currently and to agree the report with the independent lead reviewer. SCR Panel members included representation from Somerset County Council's Childrens Social Care (CSC), Adult Social Care (ASC), Public Health, Education, Barnardo's, Avon and Somerset Constabulary, Taunton and Somerset NHS Foundation Trust and the Somerset CCG.

Individual staff who were involved during the period of Operation Fenestra have also been involved in this case review, namely the police officers and the Barnardo's BASE worker, who supported one of the nine victims. Current professional staff groups from education, health, social care, community safety and police were involved in a series of focus groups.

The involvement of CSE victims and their families, who were not linked to Operation Fenestra, also provided insight into impact of abuse and how practitioners can best support children and their families. Groups of school children and a group of children looked after also contributed to the review.

The report concludes there were numerous missed opportunities when information and allegations could have led to agencies finding out what was happening to the children.

The report is being published by the Somerset Safeguarding Children Board (SSCB) following consultation with the two young women subjects of the review, one of their families, and one other victim identified through Operation Fenestra.

A multi-agency action plan has been developed by the SSCB in response to the eight review findings and incorporates actions already taken by the SSCB and partner agencies within Somerset. Board partners are held to account for its delivery.

Review Findings

Finding 1

Due to difficulty interpreting and reconciling national guidance and the law relating to sexual activity, professionals sometimes find it difficult to distinguish between informed consent for adolescent sexual activity and coercion / 'inappropriate relationships'; this can leave children being at continued risk of child sexual exploitation, especially if they are judged to be 'competent' and/or 'capable' to make such decisions themselves.

Issues / questions for the SSCB to consider:

- Are practitioners sufficiently aware of the different models of exploitation, including that of 'inappropriate relationships' and do they understand how to reach decisions about whether they are seeing abuse/ exploitation?
- Does the culture within local organisations facilitate professionals to have professional curiosity enabling them to recognise and respond to CSE?
- Are primary care and sexual health services sufficiently resourced and organised so that health practitioners are able to explore with children the nature of the sexual relationships being experienced, including the identity (and age) of any sexual partners?
- How to provide the children, parents and the wider public with consistent messages about sexual exploitation, given the contradictory and confusing national context
- Do practitioners need more training, guidance and access to expertise locally about issues around consensual sexual activity and competence / capability?
- Do current arrangements for children receiving termination of pregnancy/ sexual health services / mental health treatment ensure practitioners adequately assess the risks of child sexual exploitation and inappropriate relationships to safeguard children?

SSCB response

The SSCB recognised that confusing national guidance on CSE was an obstacle for the public as well as practitioners to recognise the difference between 'informed consent' for adolescent sexual activity, 'coercion' and 'inappropriate relationships'. It also considers it essential that all practitioners understand how to respond effectively to issues and concerns relating to sexual activity. It has therefore undertaken a range of activity to support practitioners in this challenging area of work, including the following:

- Two multi-agency practitioner conferences, **'Working Together to Tackle CSE',** were held in 2016/17, targeting a total of 170 designated safeguarding leads. The events provided an opportunity to raise awareness, develop skills in assessment and identification and for learning messages from the SCR Operation Fenestra to begin to be shared.
- The SSCB has commissioned a multi-agency CSE training programme which covers 'basic awareness', 'working with parents', 'skills and practice', 'CSE and working with children with learning difficulties'; the training also raises awareness around the 3 defined different types of child sexual exploitation. In addition, online training has been developed and made available through the SSCB website for anyone who works with children. To date, more than 1,000 staff (including social workers, social work support staff, children's centre staff, health and school staff) have attended face-to-face training and a further 500 plus have completed online training.
- Individual agencies have delivered – and continue to deliver – training to staff on CSE, supported by information and resources such as the *CSE quick guide* to raise awareness of CSE in frontline practice. Somerset Partnership, for example, developed a new Level 3 Child Sexual Exploitation training module which was rolled out across the Trust in April

2017. This module is based on recent evidence based best practice, particularly focusing on the Boyfriend model of sexual exploitation.

- A CSE Champions network, co-ordinated by the SSCB, has been developed; champions have been identified across SSCB partner agencies and are trained as CSE lead practice experts who will sustain the training programme. Their role is to disseminate learning, share knowledge and expertise to support colleagues in understanding the complexities of working with children who are or may be subject to sexual exploitation.
- A range of activity aimed at raising public awareness has been undertaken. Avon and Somerset Constabulary developed a campaign strategy to raise awareness of Child Sexual Exploitation. The first part of this strategy is aimed at raising awareness by targeting information at practitioner groups and has been developed using victim's voices to inform its key messages. The campaign call to action is: ***Ask. Ask me again and Keep asking… and CSE is happening.*** An 'Understanding CSE' leaflet specifically for parents and carers was also developed by Avon and Somerset Constabulary. Somerset County Council published a double page spread in "Your Somerset", which is delivered to every home in Somerset.
- To help children understand about healthy relationships and exploitation, a programme of specific Sex and Relationship Education (SRE) in schools continues to develop and will be supported by a future change in the law to make SRE mandatory. A Public Health Promotion Manager has been given a lead role in supporting the development of PSHE and Healthy Relationships in schools. A CSE and healthy relationships programme has been developed with Avon and Somerset Constabulary, initially targeted secondary schools in Somerset and now available to all secondary schools in Somerset. To date, teaching staff at 21 secondary schools have completed PSHE training
- The Council and the SSCB continue to provide support to schools. Around 500 school staff have completed the Barnardo's training. All education providers have been asked to identify a CSE lead and to collect data on what training they have carried out on various safeguarding issues, including CSE; this will be monitored in an annual audit co-ordinated by the local authority and reported to the SSCB. A half-termly safeguarding newsletter includes regular CSE information and guidance.
- All health services plan to provide safeguarding children supervision to all frontline practitioners working with unborn babies, children and young people. The CCG is planning a review of the quality assurance processes in place in relation to safeguarding children within termination of pregnancy services. All health services plan to provide assurances that patients pre and post termination of pregnancy (TOP) are given access to pre and post counselling.

The Board monitors the effectiveness and impact of supervision training through its audit and quality assurance activities. The 'section 11' audit will continue to be used for this purpose.

Finding 2

There is a tendency for practitioners to focus on short term intervention for perceived parenting deficits, without taking sufficient time to listen and hear the parents' own worries of risks outside the family. This can lead to the provision of insufficient support to the child and family.

Issues / questions for the SSCB to consider

- How to effect the cultural change needed for social care practitioners to listen and 'hear' parental concerns about their child's safety external to the family, even if the assessment initially focuses on relationship and parenting problems within the home?
- Do social care practitioners understand the changing model of social work practice as a result of sexual exploitation and the need to consider factors internal AND external to the family when children are exhibiting significant risk taking behaviour? Parental strength and a protective family may not be enough to keep a child safe.
- Is it possible now to provide consistent longer term family intervention to address relationship problems, especially in relation to concerns about the changed and challenging behaviour of children?

SSCB response

The SSCB recognises that some of the agencies involved did not 'hear' parents' views and worries and that the short term nature of agency interventions with the families led to insufficient support for them and a minimisation of their concerns about the risk to the children outside of the home. Practical guidance and assessment tools, supported by training, has already been put into place to support staff in identifying and responding more effectively to risks to children.

Activity has also included:

- SSCB has reviewed and updated the CSE risk and decision making tool (July 2017), which is available on the SSCB website. These tools are used routinely where practitioners suspect there may be CSE and support them in their assessment of risk.
- Practitioners have received training to recognise and respond to indicators of Child Sexual Exploitation (CSE) before it occurs and when it is taking place.
- Social Work assessments include the voice of the parent and carer and are now subject to case work audits for continued assurance.
- Early Help - CSE risk assessment has been integrated into the early help arrangements (SSCB Effective Support for Children and Families), to help identify children and young people at risk, and a missing children fortnightly review meeting is now in place to consider those children who are missing regularly and/or whether other risks have been identified.
- Assessments now incorporate parental views regarding the risks to their children.

- Consultation and support for practitioners is available via BASE (Barnardo's Against Sexual Exploitation) to support practitioners in understanding and managing risk.
- Victims of CSE and their families now receive consistent support at the right level when risk has been identified, through the new jointly commissioned CSE support service. The new regional service has been jointly commissioned with the Avon and Somerset Police & Crime Commissioner and launched in October 2017, being delivered by BASE (Barnardo's Against Sexual Exploitation). It builds on the previous service, providing support and guidance for children who have experienced CSE. In Somerset, the service will now provide support to develop the skills of practitioners, working alongside professionals in all agencies, who already have trusted relationships with children.
- Practitioners operating at levels 2 and 3 of the Somerset Effective Support for Children and Families Guidance support children at risk of CSE via Team Around the Child (TAC) and Team Around the School (TAS) processes.
- 'Step up', 'step down' and 'step in' processes are used to manage changing risk profiles and ensure that ongoing support is provided consistently at the right level where CSE risk is identified.
- Children's Services in Somerset will consider how consistent and ongoing support for children at risks of CSE can be made available, within the developing Adolescent Edge of Care strategy and the adolescent support team.
- The local authority's Targeted Youth Support team has strengthened arrangements to respond to incidents when children go missing from care or home. The independent Return Home Interview (RHI) service was launched in 2016. In addition significant changes were also made to the Police recording of missing incidents.
- RHI staff contact the children and families as soon as they are informed that a child is missing and aim to complete interviews within 72 hours. They have been trained by the Police and there are strong links between the service and the Police Missing Person Co-ordinator. This change has seen an immediate improvement in the number of interviews completed.
- Higher risk cases are discussed fortnightly by a Missing Review Panel. It considers the latest information drawn from several agencies to develop a coordinated response with partners.
- The RHI team continue to focus on improving the rate and timeliness of completed interviews and have streamlined processes and refreshed procedures in line with best practice nationally.

Finding 3

CSE investigations need a multi-agency investigative model able to develop consistent relationships with alleged victims over a long period; without this the likelihood to provide support to the children concerned, protect them from further harm and establish the evidence needed for a successful prosecution are severely reduced

Issues / questions for the SSCB to consider:

- What further measures are needed to achieve an effective multi-agency investigation into CSE concerns and allegations e.g. the instigation of multiagency strategic and operational coordination of the investigation from the point at which a Complex Crime / Critical Incident decision is declared?
- Should police officers be the professionals to provide the consistent role over an extended period, as occurred in this case and has been valued by child victims in building trust leading to disclosure? Is there scope for this function to be shared with or led by partner agencies, depending on the needs of each child?
- Are the police sufficiently resourced to be able to support complex crime investigations in CSE in the future?

SSCB response

The SSCB agrees that investigations of CSE cases are likely to be most effective when they are multi-agency from the outset and support achieving sufficient evidence for a successful prosecution. The Board also understands the importance of providing capacity to build consistent relationships with victims over a long period time, using the agency best able to respond to the particular needs of the child.

Learning from Operation Brooke about the coordination of a multi-agency approach was incorporated into Operation Fenestra, leading to its successful outcome. Other actions taken or planned by the Board and its partners are as follows:

- Avon and Somerset Constabulary, with input from partners continues to work together to develop an **holistic multi-agency problem solving** approach to tackling suspicions of CSE by implementing appropriate processes, staffing and systems. A joint problem solving workshop held in 2016 led to the development of the multi-agency information sharing pilot, Operation Topaz. Operation Topaz shifted the focus from the reactive investigation of CSE intelligence to the proactive safeguarding of victims and perpetrator disruption. The Operation Topaz pilot resulted in joint decision making regarding referrals to services to deliver the right support. This resulted in stronger alignment between those assessed as being at the highest risk to those being supported by specialist services. This pilot and its impact have been welcomed by the region and have led to the development of a business case which proposes expansion into Somerset.
- Avon and Somerset Constabulary continues to address how CSE investigations are appropriately resourced and reviewed. This led to the implementation of a

Management of Investigation process, introduced in 2015, to set out the expectations for managers in terms of the review of individual investigations. Monthly checklists are completed to ensure that staff workload, progress and welfare are monitored. Avon and Somerset police has also developed systems whereby victims and intelligence raising concerns of victimisation are flagged appropriately on their systems.

The multi-agency approach used in Operation Fenestra was ultimately successful. In future cases, the Board will ensure that the learning from this approach is applied in order to achieve optimal outcomes.

Finding 4

Linking information within and between agencies is an integral part of the safeguarding system to protect children from harm: improvements have been made in recent years, but there is scope for further development of this to protect children, especially from sexual exploitation.

Issues / questions for the SSCB to consider:

- How effective are current local processes (both within and between agencies) for identifying patterns of individual and group behaviour? Consideration needs to be given to:
  - Are we making full use of available processes to share information and protect children from harm e.g. the CSE network, Team around the School
  - Collation and analysis of the effectiveness and consistency of use of CSE screening tool
  - Analysis tools for identifying and linking patterns between individuals
  - Analysis tools for identifying individual patterns of behaviour
  - Analysis tools for identifying locations which may be of concern
  - Current arrangements for information sharing by sexual health providers
  - Potential use of multi-agency chronologies.
  - Capability of IT systems in each agency to do this
- Whether the work of the CSE network meetings should be evaluated to assess the extent to which it is able to provide a process to identify patterns of behaviour and links between suspected perpetrators and children in Somerset
- What are the main obstacles in achieving the identification and analysis of gaps in information? Are these a local or national problem? If the latter what can SSCB do about this?
- Do data protection issues [legal requirements, the implementation of these and practitioners understanding of these] cause particular obstacles in this task, especially in relation to sharing information between agencies e.g sexual health clinics, GPs and CAMHS? If so, what is the implication of this for safeguarding children and does this need to be raised nationally?
- What strategies need to be implemented to develop improved linking of information nationally and internationally and how can this be taken forward?

SSCB response to finding 4

The Board is aware of the importance of information sharing in helping to identify and protect vulnerable children. A number of actions have been taken to strengthen practice in this area:

- Avon and Somerset Constabulary 'Operation Topaz' pilot evaluation demonstrated how multi-agency information sharing can lead to proactive safeguarding of victims and perpetrator disruption. The outcome of the recent business case led by the Police, which proposes expansion into Somerset, is awaited. Flagging on national police systems of

Niche will be addressed through a national working group; it has been approved and is awaiting implementation.

- A number of **schools** in Somerset now meet regularly with Children's Social Care to share intelligence and concerns about locations and gang activity.
- Somerset County Council's Targeted Youth Support team has strengthened arrangements to respond to incidents when children go missing from care or home. The independent Return Home Interview (RHI) service was launched in 2016. RHI staff contact the children and families as soon as they are informed that a child is missing and aim to complete interviews within 72 hours. They have been trained by the Police and there are strong links between the service and the Police Missing Person Co-ordinator. This change has seen an immediate improvement in the number of interviews completed. The RHI team continues to focus on improving the rate and timeliness of completed interviews and have streamlined processes and refreshed procedures in line with best practice nationally.
- Significant changes have been made to the Police recording of missing incidents, enabling a clearer overview of potential risks and vulnerabilities.
- Higher risk cases are discussed fortnightly by a Missing Review Panel. It considers the latest information drawn from several agencies to develop a coordinated response with partners.
- Avon and Somerset Constabulary implemented and evaluated a regional CSE network to help develop improved information sharing processes across locations and consider offenders as well as victims.

The Child Exploitation subgroup monitors the impact of this activity to ensure that information is shared in a timely way, and that intelligence is used effectively to keep children safe and disrupt criminal activity.

Finding 5

Children who have experienced or are at risk of experiencing CSE need accessible, timely and skilled support for their emotional and mental health problems: this is developing in Somerset, but requires further improvement to provide for the range of need.

Issues / questions for the SSCB to consider:

- Is the SSCB satisfied that the development of current commissioning arrangements for improving children's emotional and mental health support will provide services able to meet the range of needs of CSE victims, or those at risk of becoming victims? If not, what further resources are required to be able to meet needs? NB Commissioning arrangements should include the need for long term therapeutic relationships, the potential use of volunteers to provide additional long term support, accessible services for young people and ones that understand how to support a victim in engaging in services.
- Is the SSCB assured that there is sufficient knowledge and expertise of CSE in the CAMHS service to inform an appropriate response to children who do attend appointments and to those who do not attend appointments?
- How will staff within these services be equipped to have sufficient knowledge and understanding of safeguarding children at risk of, or already harmed by, CSE: this includes the need to share early concerns about CSE with other agencies to assess risk and understand when there is a need to use child protection procedures
- The SSCB should explore the extent to which adult services understand the issue and respond appropriately to those who continue to be abused by perpetrators once they turn 18 or 21, or survivors who are no longer being abused but disclose previous CSE or those that are suffering from the impact of earlier abuse.

SSCB response

The SSCB regards it as essential that children receive timely and skilled support with their emotional and mental health problems. Whilst this is developing in Somerset, more work needs to be done to provide a range of support services for children. A number of actions have already been taken to ensure that the workforce is suitably trained and skilled, and effective support services are in place:

- Somerset County Council and the Avon and Somerset Police & Crime Commissioner have jointly commissioned a new regional support service. The service, delivered by BASE (Barnardo's Against Sexual Exploitation), provides support and guidance for people who have experienced CSE.
- All SSCB partners will ensure they are providing robust CSE training that is based on best practice guidance, includes the findings from this SCR and is specific to their particular agency/service. This being supported by the development of a checklist for issues to be covered in single and multi-agency CSE training.
- Partners will continue to be asked to provide the SSCB with assurance that children and young people at risk of, and victims of, CSE are getting the right services at the right time, delivered by the correct agency, in line with the SSCB Effective Support document.

- Somerset Partnership delivered a bespoke Level 3 training module to CAMHS professionals in May 2017 that was informed by emerging learning from this SCR. The provision of formal safeguarding children supervision for CAMHS professionals was implemented by Somerset Partnership in May 2017.

The Child Exploitation Subgroup, supported by findings from single and multi-agency audit and assurance, will be overseeing the adequacy and effectiveness of the support received by children and their families.

Finding 6

There is a need for good early multi-agency collaboration along with consistent and persistent relationship based intervention in this complex area of work; without this there is the potential of unrecognised risk and individual practitioners feeling isolated in the safeguarding of children considered to be vulnerable to sexual exploitation

Issues / questions for the SSCB to consider:

- Is the SSCB confident that the One Teams and the Team around the School are providing the multi-agency information sharing, co-ordination and planning needed in suspected CSE cases below the threshold of CSC involvement?
- If not what are the obstacles and how can these gaps be addressed?
- Are there problems relating to lawful information sharing at these meetings and if so, how is this being managed?
- Does the current way services are delivered enable practitioners to provide a consistent trusting relationship with children? Do senior managers in agencies understand the time commitment for staff in developing the relationships needed for vulnerable children?
- Do practitioners and managers understand the need for persistence and curiosity when developing such relationships?
- Does the mental health inpatient unit provide a system of key worker / lead professional with responsibility to develop such a relationship with each child?
- Is the SSCB confident that multi-agency pathways based on multi-agency risk assessment are now working well to safeguard children from harm from CSE?

SSCB response

The SSCB appreciates the significance for children of consistent trusting relationships and how in this review, there were repeated examples of schools and adolescent support workers reporting concerns about the victims and there being little subsequent intervention by statutory services that led to some of the multiple missed opportunities to discover what was happening. SSCB also understands the need for practitioners to be well trained and supported in their work with vulnerable children. We will therefore continue to work to achieve this as follows:

- The SSCB continues to strengthen and embed the provision of Effective Support through early help interventions with children and families in Somerset.
- A Lead (Somerset) Co-ordinator has been appointed to support One Team co-ordinators to establish consistent and robust approaches to information sharing, updating agency records, recording and sharing of actions and measuring performance outcomes. It is anticipated that this will strengthen the practitioners' ability to build consistent and trusting relationships with children and young people through the One Team model (where One Teams are in operation). This approach also aims to build stronger linkage of concerns raised at One Teams about possible CSE activity which can feed into Team around the School (TAS) meetings and help facilitate appropriate support for the child at the earliest opportunity.
- The time commitment for staff in developing the relationships needed for vulnerable children and the need for practitioners and managers to understand the need for persistence and curiosity when developing such relationships, is reinforced through the SSCB multi-agency training.
- CAMHS is ensuring that children who are placed in Somerset from elsewhere will also retain their community mental health care co-coordinator from the placing authority. This practitioner will have lead responsibility for liaising with partner agencies and families. In addition, when children are inpatients at Wessex House they are assigned a key worker/key nurse. Therefore, each young person will have a community and an inpatient lead who will work together to support the child.
- The SSCB is developing a multi-agency care pathway for child sexual exploitation which includes all emotional and mental health support services in Somerset and considers the routes into services (e.g. mental health services, missing children, CLA, those in the criminal justice system) which may be followed by CSE victims and those at risk of CSE.

The Board will be seeking regular assurance about the continuing effectiveness and impact of these arrangements, to include feedback from young people.

Finding 7

The current arrangements nationally in relation to piercing and tattoo salons do not adequately address safeguarding risks for children.

Issues / questions for the SSCB to consider:

- The SSCB to consider how safeguarding can be improved locally and whether a consistent approach can be developed for all District Councils, based on the good practice developed by Sedgemoor District Council?
- The SSCB to raise concerns nationally about the vulnerability of children given the lack of safeguarding provision in the law and regulations relating to piercing and tattoo premises.

SSCB response

The SSCB welcomes how the review has highlighted that the law and legislation for tattooing and piercing salons needs strengthening from its current focus on health and safety and infection control, to include responsibilities for safeguarding children. In order to achieve improvements both locally and – hopefully – nationally, we have taken or plan to take the following actions:

- Members of the SSCB Child Exploitation strategic subgroup are working across districts to ensure that staff working for tattoo and piercing establishments in Somerset are aware of and vigilant about safeguarding and CSE and know how to escalate concerns. This work is being led by the district councils.
- A letter is being sent from the SSCB to the appropriate Minister to highlight the weaknesses in the law about the safeguarding of children within tattooing and piercing premises, given the current framework of regulations relating to such establishments.
- District councils have undertaken innovative work with taxi-drivers and social landlords across 2016/17. Specifically, Taunton Deane Borough Council - who led and mentored other district councils - produced a handbook for taxi-drivers, highlighting the signs of CSE and what action they should take to alert authorities of any suspicions. This approach to raising awareness is now being extended to tattooing and piercing parlours, kebab shops and clubs.

This matter will be kept under review by SSCB.

Finding 8

The practice of some primary care medical services (as advised by medical indemnity insurers) is contrary to statutory requirements in relation to their involvement in serious case reviews; this risks undermining the ability to learn lessons and improve safeguarding of children in the future

Issues / questions for the SSCB to consider:

- What further strategies can the SSCB and CCG and NHS England develop to address the lack of co-operation of some local primary care providers with the statutory requirements for information sharing as part of serious case review processes?
- What actions does the SSCB need to initiate nationally, alongside the CCG and NHS England, such as reporting this obstacle to both the DfE and DH?

SSCB response

The SSCB is concerned about the underlying conflict between statutory requirements to provide information and advice provided by some medical indemnity insurers and the implications for improving the reliability of multi-agency safeguarding systems. There were limitations in the information available from primary care providers for the purposes of this serious case review. Of the 9 victims of perpetrators A and B, primary care information was not provided at all for 3 of them. This is unacceptable. We are therefore taking the following actions:

- The CCG has contacted the Regional Liaison Advisor at GMC regarding information sharing for SCRs and conflicting advice given to primary care staff by the medical indemnity insurers. The Regional Liaison Advisor delivered a training session on information sharing and SCRs to GPs at the GP safeguarding lead training day, quoting GMC guidance.
- Following advice from the NHSE deputy medical director, the SCR panel chair wrote to the GPs who had refused to disclose information on the subjects of the serious case review, outlining GMC guidance about information sharing.
- The CCG, in partnership with NHS England and the General Medical Council, plans to support primary care staff in clarifying their roles and responsibilities in relation to serious case reviews.
- The CCG has requested advice and support from the Deputy Safeguarding Lead for NHSE South West in relation to information sharing by GPs for Serious Case Reviews.
- A request to attend an LMC meeting to discuss information sharing by GPs for serious case reviews has been made.

Depending on the outcome of the above activities, the Board will take further action as necessary.

Conclusion

The SSCB will ensure that the actions above will be overseen by the Learning and Improvement Subgroup. Any examples of a failure to implement or make timely progress with an action will be brought to the attention of the full Board in order that they may be addressed.

CSE remains a strategic priority for the Board:

"Children who are at risk of, or subject to, all forms of exploitation and abuse (including children missing from home, care or education) are identified and safeguarded" (to include CSE, trafficking, county lines modern slavery."

The Child Exploitation Subgroup will continue its work to progress the SSCB's CSE strategy in Somerset, raising awareness of CSE in all its forms, promoting effective inter-agency working, disrupting and securing prosecutions of those who seek to abuse and exploit any child and above all, helping the children who have been or may be vulnerable to exploitation and abuse and their families.