DONCASTER SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

OVERVIEW REPORT

ADULT K

Died 2018 – 19 years of age

Independent Reviewer: **Chris Brabbs**

Date of report: **27th October 2019**

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1. THE REVIEW PROCESS

Circumstances leading to the Review

1.1 This Safeguarding Adults Review (SAR) [1] was commissioned by the Independent Chair of the Doncaster Safeguarding Adults Board (DSAB) following the death in August 2018 of Adult K (referred to as K from hereon). A Coroner's Inquest in April 2019 concluded that her death was drug related.

1.2 This decision took into account that there had been long standing multi agency involvement with K and her siblings because of parental neglect which resulted in her becoming looked after by the local authority when she was 14 years old. Both prior to and after K became looked after, there were concerns that K was at high risk of sexual exploitation.

Purpose of the Safeguarding Adults Review

1.3 As set out in the Statutory Guidance to the Care Act 2014 the purpose of a SAR is to:-

- establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk;

- determine what agencies and individuals involved might have done differently to prevent the harm or death;

- review the effectiveness of multi-agency safeguarding arrangements and procedures (both multi-agency and those of individual organisations);

- identify the learning, including examples of good practice, and apply these to improve practice and partnership working.

Key Lines of Enquiry / Key Issues

1.4 In drawing up the terms of reference, it was agreed that the main focus of the SAR would be to explore the effectiveness of multi-agency working and processes in responding to concerns that K was a victim of sexual exploitation both pre and post her becoming 18 years of age. In particular, the SAR would seek to draw out the wider learning in respect of:-

- any differences in the response to sexual exploitation which flow from the change in legal status when victims reach 18 years of age including how this can affect professionals' engagement and information sharing;

- the arrangements to support transition into adulthood, and how current referral pathways and application of eligibility criteria affect access to future support;

- multi-agency processes for assessing risk, protection planning, and co-ordination of action to disrupt or pursue alleged perpetrators both in respect of adult and child victims.

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[1] *Section 44 of the Care Act 2014 requires a Review to be carried out where "An adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult"*

Time Period Covered by the Review

1.5 In order to explore the above issues, it was agreed that the SAR would cover the period from August 2016 when K was 17 years old and approaching transition to adulthood.

Agencies Involved

1.6 The following agencies contributed to this SAR:-

Doncaster MBC Adult Safeguarding
Doncaster Children's Services Trust
Rotherham Doncaster and South Humber NHS Foundation Trust
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Doncaster CCG (Primary Care)
South Yorkshire Police
South Yorkshire Ambulance Service

1.7 Chris Brabbs, an Independent Safeguarding Consultant, was commissioned to lead the review Panel and be the overview report author.

Involvement of Family Members

1.8 Information about the SAR process was sent to K's mother and grandmother to provide them with information about the SAR process with an invitation to contribute their perspectives. However no response was received. NB further letters will be sent prior to publication to offer the opportunity to share the review findings.

2. NARRATIVE OF KEY EVENTS

Prior to Review Period

2.1 After Care Orders were made in respect of K and her siblings in February 2014, K had a number of foster and residential placements including some out of the area.

2.2 Following an unsuccessful local residential placement when K frequently went missing, she was placed with foster parents in Nottinghamshire in April 2014 where she received a high level of input from the Barnardos CSE team. The placement lasted 9 months with reports of considerable positive progress. However, as the placement progressed K started to go missing more regularly, often making her way back to her mother or other members of the extended family.

2.3 As a consequence, in early 2015, K was placed back in Doncaster with foster parents who had previously provided her with respite care. K's preference had been for independent living or a return within the family. However, the risks were considered too high.

2.4 This placement proved unsuccessful, and K, now aged 16 years, was moved to a placement in Northamptonshire where she received therapy and weekly CSE input. Again, K struggled with the boundaries and the protection that this placement offered her, and she disengaged from the placement with a high level of absconding. There were also clear indicators during this placement that she was at risk of child sexual exploitation (CSE).

Key events during the period covered by the SAR

From August 2016

2.5 In August 2016, when K was 17 years of age, she was brought back to Doncaster and placed in semi supported accommodation with a safety plan that included a late evening curfew and agreement for her to stay with her grandmother twice a week.

2.6 Quite quickly after the placement commenced, a strategy meeting was held in response to several missing episodes and suspicions that K continued to be at risk of CSE. These stemmed from reports of her being seen with older males in the town centre and being driven away from her grandmother's house. She was also said to have a 27 year old boyfriend who had given her clothes and gifts although K stated he was just a friend. K was referred to Barnardos for the involvement of a specialist CSE practitioner.

2.7 Two further strategy meetings were held in September 2016 where the risks were judged to be increasing given the frequency of the missing episodes. K was often found at her mother's or uncle's address. During September and October 2016 the police served abduction notices on K's mother, uncle and partner. There were occasions when K asked to be collected from locations outside of the home area including the East Midlands. There were also fears that K was in touch with Male A, whose name was on the sex offender register, and who had previously been arrested after being found with K when she was 15.

2.8 The Doncaster placement was ended after 3 months because it was concluded that K could not be kept safe locally and she was moved to a placement in West Yorkshire in October 2016. However, this placement only lasted one month because K started soon started to go missing. The unit also voiced concern that K had admitted to taking cocaine, and was "sex working" which was making it difficult for the unit to protect the other 2 girls in the placement. One of the other girls disclosed that during one of the missing episodes, K had tried unsuccessfully to pressure her into having sex with a 50 year old male whom K had contacted. K had taken crack cocaine and they had also visited K's mother.

2.10 Following an overdose of paracetamol which resulted in admission to hospital, K was brought back to Doncaster in mid November 2016 and placed in semi supported accommodation. K soon started to go missing for several days at a time which resulted in further strategy meetings. Although this remained her official placement for 6 months K rarely spent time there.

2.11 At a Looked After Child (LAC) Review in early December, it was noted that K was not in education or employment (NEET) and there were difficulties in securing K's engagement with her transition plan to prepare her for independent living. A plan was made to progress this which would ultimately see case management responsibility transferred to the Inspiring Futures Team which supports care leavers. In addition, regular strategy meetings would continue to be held given the continuing risks of sexual exploitation.

2.12 At a strategy meeting in late December 2016 the safety plan was changed to take account of the fact that K was staying at her grandmother's most of the time and only returning to the unit once a week to collect her weekly living allowance. An agreement was made therefore that K could stay with her grandmother as long as she retained in constant touch with the unit. However, she frequently did not do this which resulted in her being reported missing or absent.

2017

2.13 Later in January 2017, in response to one of these episodes, K was located at the address of a 35 year old man, Mr B, who was K's new boyfriend. At a subsequent strategy meeting the view reached was that despite the difference in age, this appeared to be a consensual relationship which did not seem to present a risk. it was agreed that K would be treated as "absent" from the unit rather than missing if she was staying with Mr B as long as she continued to maintain contact with unit staff.

2.14 However, concerns soon started to emerge about this relationship because of observations that Mr B was "controlling". In March, K disclosed, in some distress, that she had been a victim of an incident of physical domestic abuse which had been witnessed by her grandmother. She also stated that Mr B was using cocaine. Mr B subsequently made counter allegations that K was involved in commercial sexual exploitation with her mother, spending time at her uncle's house who was subject of an abduction notice, and that the latter was using heroin.

2.15 The strategy meeting at the end of March noted that K was spending more time at the unit to complete the independence work, and she seemed to be spending less time with her grandmother who it was thought might be challenging K over her continuing relationship with Mr B. Concerns were also raised that K might be being exploited by Mr B to fund his lifestyle.

2.16 Given the information that K may have been drawn into commercial sexual exploitation, it was agreed to refer her to the Amber Project which works with "street workers". In addition, consideration would be given to a referral for an independent domestic violence advocate.

2.17 At the LAC Review meeting in mid April just prior to K's 18th birthday, it was noted that K had not yet been allocated a personal adviser (PA) from the Inspiring Futures Team and a recommendation was made that her case be transferred as a matter of urgency. It was also agreed that a referral would be made to Care Leavers' risk panel and that the LAC Nurse would stay involved until K's 19th birthday. On the positive side, it was noted that K had engaged better with services on offer, had completed her independence work, and had made applications for housing and benefits. Pending an offer of housing, the semi supported placement would continue for a further 3 months.

2.18 In April 2017 Mr B made allegations that K was out of control. She was said to be spending time with her mother, taking crack cocaine, and injecting heroin. She was also said to have visited Mr B with an associate of K's mother whom Mr B alleged had abused her from age 13. The unit also reported that K had been picked up in a car by 2 unknown males.

K became 18 years of age in April 2017 (change in legal status).

2.19 In June 2017, K moved in with Mr B. During a visit to the Project 3 sexual health and drug and alcohol service, the practitioner raised the issue of the age difference with K who provided reassurance that there was no coercion involved. The practitioner was concerned that K did not want Mr B to know her surname, and that she had appeared distressed and distracted after taking a telephone call.

2.20 In July 2017, K's case was transferred to the Inspiring Futures Team. The allocated social worker carried out a sexual exploitation screening assessment with K who confirmed she was living with Mr B and described herself as feeling very safe.

2.21 Between July and September 2017, K made further visits to Project 3 but did not always return for treatment for a sexually transmitted infection.

2.22 In February 2018, K's case was transferred to a personal advisor (PA) within the Independent Futures Team. There was also regular involvement from an education, training and employment (ETE) co-ordinator who arranged a number of short work placements in the hair and beauty field. Although the PA and ETE Co-ordinator tried on several occasions to establish where K was living, she refused to disclose this other than to say she was living in Rotherham with her boyfriend and professionals did not need to know more. K requested that all mail should be sent to her grandmother's address.

2.23 In April 2018 K accepted the offer of flat in a town near to Doncaster but decided that she could not move in until some essential repairs had been completed. The PA continued to liaise with the housing provider through May and June to progress this.

2.24 On the day before she died, K rang and spoke to the ETE Co-ordinator as the PA was unavailable that day, asking if it would be possible for her to move into a shared property until her flat was ready. There was nothing concerning noted in that call.

3. INTRODUCTION TO THE REVIEW FINDINGS

3.1 The review findings are presented around the following themes:-

- K's exposure to risk
- multi-agency response to the risk of child sexual exploitation
- response to missing episodes
- sexual health issues
- substance misuse issues
- transition into adulthood
- issues around engagement

4. K'S EXPOSURE TO RISK INCLUDING SEXUAL EXPLOITATION

Risks posed by K's family

4.1 K's immediate and extended family were viewed by professionals as posing a huge risk. K's mother was known to misuse substances and K disclosed that when she was living at home, her mother had plied her with alcohol and drugs. K's mother was believed to use prostitution to fund her drug use both through her direct involvement but also drawing others into sexual exploitation. It was established that K was frequently taken and left in the homes of her mother's male associates.

4.2 During K's time in care, professionals had suspicions that K was possibly being exploited financially by her mother and her boyfriend to fund their drug use although no firm evidence of this was ever established. K's grandmother also had links with CSE previously and a former partner had been imprisoned for sexual assault on a child. Other members of the family were also perceived to be a risk particularly her uncle and his partner.

4.3 K was very easily led by family members would trust their views, and found it hard to say no to them. K found it difficult not to mimic behaviour learned from them and her late entry into care made it difficult for professionals to draw K away from these negative influences.

4.4 The fact that K's family were a massive draw for her appears to have been a significant factor in her going missing given the frequency she was located at their addresses. These risks were exacerbated by the family not being prepared to work with agencies to keep K safe and not reporting when K turned up at their addresses.

4.5 K was intensely loyal to her family and very protective of her mother – the relationship being viewed as a “trauma bond”. This appeared to involve a role reversal with K being worried about her mother’s whereabouts when she was unable to make contact but there was little evidence that this was reciprocated. K was aware of professionals’ concerns about her mother and understood why she was unable to live with her.

Risk from other adults

4.6 Once in local authority care, K often spent time in environments which placed her at risk with descriptions by professionals of her continually “seeking out” and spending time with adults who posed a risk. K was thought to be copying her mother’s behaviours in arranging to meet males at their houses.

4.7 A concern for professionals was that K was quite petite and appeared younger than her biological age which was viewed as increasing her vulnerability to the risk of exploitation. Although K acted as very mature for her age in these environments, the perception was that her emotional development, cognitive functioning and decision making was not representative of a adult. In addition, she was very trusting and would easily make friends with others. When she met someone she believed that she "knew them" even though she had only just met them.

K’s perceptions of risk

4.8 K’s childhood experiences had a marked impact on her view of her situation and her behaviours. From a very young age K had necessarily developed strong survival skills and resilience, with a fear threshold that was said to be much higher that most children.

4.9 While K would sometimes acknowledge that she understood why professionals were worried about her, she did not perceive herself as being at risk - often describing her experiences as "fun" and exciting". Her view was that she did not need to change what she was doing. Although K could articulate a good understanding of grooming and exploitation as a result of the extensive work done with her around these issues, she did not perceive that this was something that was happening to her.

4.10 Within the review discussions the observation was made that a contributory factor to K frequently making what appeared to be unsafe choices, was that the process and consequences of sexual exploitation was something she had grown up with and she would have come to view these as a “normal” part of life. Consequently when professionals tried to work with her using a “consequences” approach, this did not have the hoped for impact.

4.11 This lack of insight became a concern during the 2016 West Yorkshire placement when it appeared that K may have started to involve other young females in her activities. This stemmed from the disclosure from another young person in the placement which was referred to in the narrative. On this occasion the police decided to take no further action because it was recognised that K was a victim as well as a possible perpetrator. However, when the risk of K being criminalised was raised with her she was said not to have appeared overly concerned.

4.12 The extent to which K appeared unaware of the risks was underlined by K stating that she wanted to be a porn star when she became 18 years of age.

5. PROFESSIONALS' RESPONSE TO RISK

Use of Strategy Meetings up to K's 18th birthday

5.1 Nine strategy meetings were held during the nine month period between August 2016 and April 2017. This very high frequency, and consistency of those attending, reflected the strength of the partnership working in considering quickly the implications of new developments in K's situation and agree changes to the safety plan.

5.2 The detailed record of the discussions show how a structured approach was adopted to risk assessment with each of the specific concerns listed and balanced against possible protective factors. This provided a clear audit trail as to the rationale for the conclusions reached and actions agreed. The notes also show that there was agreement that despite the fact that K would soon reach 18 years of age, there could be no "grey areas" and no let up on protective action to be taken because K was still a child.

Intelligence gathering

5.3 A major challenge throughout the case which hampered professionals' efforts to protect K, and pursue possible perpetrators, was that K was always extremely secretive and would not share information about her whereabouts or who she had been associating with. Unpicking the circumstances relating to her missing episodes was therefore extremely difficult.

5.4 Professionals tried to overcome this in a number of ways including trying to "ping" K's mobile phone to establish her whereabouts. They also shared any snippets of information and possible addresses to enable further enquiries to be made about possible female associates she referred to, or males she may have been associating with. However, a further difficulty in following these enquiries up was that, unlike many cases involving sexual exploitation, K's name never seemed to crop up when other potential victims were being discussed through multi-agency CSE processes.

Placement Decisions

5.5 The fact that K experienced 6 placement moves underlines the challenges professionals faced in trying to keep K safe. This resulted in some robust but healthy exchange of professional perspectives within the strategy meetings about the rationale for the type and location of placements being considered given that each brought risks as well as potential advantages.

5.6 The 2016 Northamptonshire placement had been seen as the opportunity to put some distance between K and her family. K herself had been asking for this as she acknowledged she was not strong enough to sever ties with people in Doncaster who were a potential risk. In opting for this out of area placement, it was acknowledged that this increased the possibility of K going missing, with all the associated risks, in order to get back home.

5.7 However, it was concluded that this was a risk worth taking, and for several months that rationale appeared vindicated until K found the restrictions of the placement too great and she began to disengage accompanied with a high level of missing episodes. A key factor in the local authority's decision to bring K back to Doncaster were the reports of K being picked up or returning in different vehicles when she went

missing, and her often being found in areas which were recognised as CSE "hotspots".

5.8 Given these reports, police officers at the subsequent strategy meeting expressed concern about the choice of Doncaster placement as this could be setting K up to fail. This was partly because it was near to the town centre's "red light" district, but also it increased the chances of her gravitating to her mother whom she had been making links with again. The social worker explained that she had been trying to get agreement to a specialist placement but this had not been approved by the resource panel. The discussions led to a shared view that location did not appear to make a difference, and that regardless of where she was placed, K would always manage to get to where she wanted to be given the experience of the Northampton placement.

5.9 However, this view was set aside when the local authority decided to end the placement, and again moved K out of the area having concluded that K could not be kept safe in Doncaster because of the risks posed by the family. As with the previous out of area placement, the rationale was that this would provide a period of respite and time for K to "pause, reflect and start again". In addition, the perceived advantages were that K would receive more support because she would be in a setting more akin to a residential children's unit through being in a shared house with just 2 other girls in placement. In addition, she would continue to receive regular visits and support from the specialist CSE practitioner.

5.10 Police officers questioned the wisdom of this move given the previous conclusion that K would be at risk wherever she was placed, and there would also be the possible additional risks of K being in an area that she did not know. In the event this placement proved short-lived because of the unit's concern that K was "sex working" and the risks this posed to the other residents.

5.11 Initially, pending identification of a new placement, the Children's Trust had proposed that K should stay with her grandmother but this was not pursued after being challenged by the police given the grandmother's record of not co-operating fully with agencies. During the West Yorkshire placement there had been suspicions that K had been staying at her grandmother's when she went missing which the latter denied.

5.12 While recognising the risks in bringing K back to Doncaster, the decision made by the Children's Trust to place K in semi supported accommodation appears to have been a pragmatic step that would make it easier for professionals to continue the work with K to prepare her for independent living as she was fast approaching her 18th birthday.

Safety Planning

5.13 That pragmatism was also evident in the approach to safety planning. Immediately after the placement started, K started to go missing for long periods and was located with one or other family members. As it was evident that K was not going to stay at the placement, a decision was made that the risks would be better managed by giving approval to K staying with her grandmother as it was hoped that this would minimise the chance that K would spend time with her mother or uncle. This approval took account of previous concerns about the grandmother's ability to keep K safe and professionals' experience of her disguised compliance.

5.14 Although K's grandmother was not regarded as a strong safeguard for these reasons, it appeared that generally when K was with her, they engaged in activities which were described as "normal" and did overly place K at risk. However, it is evident that K liked being there because she could do what she wanted. This appears to be the explanation for K saying that she did not want her grandmother to be assessed as a possible carer in case this was turned down.

5.15 The safety plan did include a requirement that K maintained regular contact with unit staff each day to make sure she was there. However, as previously, K and her grandmother did not always comply with this which resulted in occasions when K was reported missing.

6. RESPONSE TO MISSING EPISODES

6.1 K was reported to the police as missing on 98 occasions between December 2011 and April 2017. Agencies identified these as being related to a mixture of factors either because K wanted the opportunity to engage in "typical teenage" behaviours, or was targeted by adults who intended to exploit her, or to meet with people she had spoken to online. K was perceived to take any opportunity to abscond, and was very inventive in how to evade staff which sometimes contributed to a delay in her being reported missing.

6.2 Every report of K going missing was responded to through active police searches to locate her at all known addresses. Police officers and care staff would usually try to ring K unless it was believed she was in a situation where telephone contact might increase the risk. Staff at her various placements applied a proactive approach, and would respond to requests to pick K up from agreed locations once she made contact.

6.3 The fact that K's family did not engage with social care or the police, impacted on the length and severity of the missing episodes as they often kept her hidden. This reinforced K's tendency to secrecy and willingness to engage. Although return interviews were carried out, K shared very little information.

6.4 The steps taken to locate K reflected the robust approach that is adopted when young people go missing in Doncaster. A particular strength of the multi-agency arrangements is that two specialist police missing officers (MPOs) are co-located with CSE team. This ensures close liaison, consistency of involvement, and their getting to know the children through the direct contact they have either alone or jointly with social workers.

6.5 There was also appropriate application of the criteria as to whether K should be treated as missing or absent. The safety plan allowed K considerable leeway and if she stuck to the requirement for her to keep in touch with placement staff she would be regarded as "absent". However, when K did not adhere to this, or her grand-mother could not confirm she was there when telephoned, then K would be reported missing. Similarly, when K was located at the address of Mr B, she was treated as absent by the police. This was because this was a relationship which Doncaster Children's Trust was aware of and had accepted, and as K wanted to be there, there were no obvious reasons to remove her.

Use of Abduction Notices

6.6 Considerable use was made of abduction notices which the police served on various members of the family and also other males. The review heard that their use would have been greater but for the difficulties in gaining information from K as to where she had been and who she had been with.

6.7 It is evident that the decision to issue these followed careful consideration of the "pros and cons" of this step being taken. The rationale in serving a notice on K's mother was that K was likely to avoid going there because K would not want her mother to be arrested, and her mother would also want to avoid this. There was some evidence that this analysis proved well founded as there were occasions when K asked to be picked up from the area nearby when her mother had not let her in.

6.8 There were also in depth discussions between the police and social workers about the option of serving a notice on K's grandmother during the earlier placements. However, on balance it was decided not to issue a notice because it was relatively safe for K to be there and made it more likely that K would be located more quickly. A key factor in this decision was the recognition that K's grandmother was the one person K would always go to if she was in trouble, and agencies did not want to remove the option of K using her address as a relatively safe "bolt-hole".

7. SUPPORT AROUND HEALTH ISSUES

7.1 Throughout her time in care, there was evidence of consistently good practice in assessing, monitoring and supporting K around her health needs, and high levels of information sharing. A positive factor was the continuity of involvement of the LAC Nurse who was proactive in following up any issues from the LAC reviews, strategy meetings and annual health assessments – the latter always being carried out in accordance with statutory timescales.

Sexual health issues

7.2 K received considerable guidance in regards to sexual health, healthy relationships and exploitation, from a range of professionals including her social worker, the LAC nurse, residential staff, specialist sexual health nurses and practitioners from the CSE team. When placed out of area, arrangements were always made for K to access sexual health services when she returned from missing episodes. On occasions K would request this herself which reflected professionals' overall experience that K was proactive in seeking medical advice.

7.3 Despite this extensive input there were ongoing concerns regarding K's ability to apply the advice provided, and whether she fully understood the risks. On occasions she confirmed that she had had multiple partners and had not practiced safe sex which she said was her choice.

Engagement with Project 3 (Young person's sexual health and drug and alcohol service)

7.4 There was good liaison between the LAC nurse, Project 3 and the CSE team in relation to sexual health issues. On the advice of the LAC nurse, K had first attended Project 3 in September 2016 because she wanted the contraceptive implant removing which was causing her difficulties. Advice was given and the contraceptive pill prescribed.

7.5 In December 2016 K again visited the drop in clinic to request removal of the implant, but left before this could be explored after receiving a telephone call which caused her to be come agitated. K then did not attend 2 further appointments that were offered that month, and she was discharged in June 2017 in line with the service's policy as there had been no further contact for 6 months.

7.6 Between July 2017 and March 2018 there were several occasions when K sought treatment having tested positive for a sexually transmitted infection (STI), but often she did not attend follow up appointments arranged with Tri-health for treatment. [2] K was also advised to recommend to Mr B that he attend Trihealth adult sexual health service for treatment but it is not known if K passed on this information. K was discharged by Project 3 in June 2018 when there had been no further contact and because by then she was 19 years of age and outside the service's remit.

8. SUBSTANCE MISUSE ISSUES

8.1 Given that K's death was drug related, the SAR explored what was known about her misuse of substances.

8.2 The perspective of the Inspiring Futures Team was that there was never any certainty about K's use of drugs. During their involvement, there was just one occasion when it was suspected that K had taken substances when she attended a meeting with her PA in October 2017. K confirmed this was the case when this was raised with her at a later date.

8.3 In the report submitted for the SAR scoping meeting, the service made the comment that the historic concerns recorded by the LAC social worker in 2016 were based on what she had been told by others, including K's previous partner, not from any direct observations. This comment would suggest that the service had not picked up the full history in respect of professionals' concerns and involvement around K's substance misuse which she had sometimes admitted to.

8.4 K had first been referred to the Betterdeal young person's drug and alcohol service in Doncaster in January 2014 due to her cannabis use and being at risk of further drug taking. K engaged with six education and harm reduction sessions, and was also offered support regarding parental drug misuse. Although this could not be confirmed, the review heard that this number of sessions would indicate a person was being treated for actually misusing substances whereas awareness raising of the dangers would usually be covered in one session. K was discharged after 6 months because she did not wish to continue.

8.5 K was re-referred by her social worker in September 2015 to Project 3 [3] for support around alcohol and legal highs, [4] and the practitioner attended one of the strategy meetings. However, K was discharged before she could be seen because she missed the first appointment and was then moved to the Northamptonshire placement. The unit there tried unsuccessfully to carry on this work, but K declined to be referred to the substance misuse team either there or in Doncaster.

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2 *Tri-health is the sexual health service for adults and located in the same building as Project 3.*

3 *Better deal became part of Project 3*

4 "*Legal highs" was the term used to describe substances that mimic the effects of illegal drugs, such as cocaine, ecstasy and speed, which had been tweaked at a molecular level to avoid these being covered by the Misuse of Drugs Act 1971. At the time, these could be sold openly on websites and high streets across the UK. The Psychoactive Substances Act which came into force on 26 May 2016 implemented a blanket ban on New Psychoactive Substances (NPS) in the UK.*

8.6 The strategy meetings heard the social worker's perception that K's misuse of substances appeared to be recreational rather than being an addiction, and that she would not go out with the intention of taking drugs, but would take them if offered. K had also admitted to using substances when she was not feeling confident in the company of others. K also smoked cigarettes which apart from the health concerns, placed her at risk of exploitation because she would approach strangers for cigarettes or lighters.

8.7 A concern was that K would try anything, and despite her being used to seeing the effects of drug misuse within the family, she did not appear to have a good understanding of the limit of how much she should take, and drugs that should be avoided. In addition, K sought to play down the potential risks, for example when she admitted to her social worker in November 2016 that she had taken crack cocaine.

8.8 The allegations made by Mr B in April 2017, if true, are concerning. In addition to taking crack cocaine, he alleged that on one occasion he had found K injecting heroin and that she did not seem to know what she was doing as there was a lot of blood. However there was no corroborating evidence to support these allegations.

8.9 The adverse impact of the substance misuse was noted at the strategy meetings with descriptions of K presenting as nervous, paranoid, and unable to communicate effectively. These traits were accompanied with physical signs of K appearing unkempt, having dilated pupils, and being unable to eat or sleep. This led to some speculation as to whether the reason for K sometimes staying out late was to avoid people seeing her when she had been abusing substances because the signs were so evident.

9. TRANSITION TO ADULTHOOD

9.1 The SAR explored 3 key issues in respect of K's transition to adulthood:-

(i) the support to enable K to prepare for living independently;

(ii) the arrangements for K's case to be transferred to the Independent Futures Team;

(iii) the assessment of risk of further sexual exploitation and / or domestic abuse.

Preparation for independent living

9.2 Although a transition plan had been drawn up well before K's 18th birthday, professionals experienced difficulty in securing K's engagement with the work to prepare her for independent living despite her saying that this was her goal. It was noted that in common with many young people in her situation, K struggled to understand the many practical challenges she would need to deal with to support herself and make the transition successful. There were also delays before K acted on advice to sort out essential practical matters in terms of obtaining a national insurance number and opening a bank account for her welfare benefits to be paid into. While K was very adept at securing places on courses or work placements where she could train, she did not always follow these through.

Transfer to the Inspiring Futures Team

9.3 The transfer to DCT's Inspiring Futures Team did not take place until 3 months after K's 18th birthday although the plan for this to happen had been identified at the December LAC meeting. The Review heard that the delay was because of changes being implemented at the time to return the Inspiring Futures Team back into a 16+ service. This involved some of the social workers transferring in from the locality looked after children's teams. [5]

9.4 However, the late transfer did not impact on the support provided to K because the LAC social worker continued her involvement until transfer was effected with a comprehensive handover process and full sharing of information. Although there was no longer a statutory requirement to do this, an experienced social worker was allocated from the Independent Futures Team, rather than a personal advisor (PA), because K's case was judged to be complex. The social worker remained involved until February 2017 when a PA took over responsibility.

Risks at point of transition into adulthood

9.5 At the LAC Review in April 2017, just prior to K becoming 18 years of age, there were serious concerns about the nature of her relationship with her relatively new boyfriend Mr B especially in the light of the incident of domestic abuse and his substance misuse alleged by K.

9.6 K was quite open with the LAC social worker about the relationship and was happy for the social worker to meet Mr B. During a visit to his home, the social worker's observation was that he behaved indifferently towards K, and she in turn appeared to be submissive to his views and worried about what professionals might say to him. Although K appears to have recognised the relationship was proving problematic for her, and she had ended it at one point, she had then gone back to live with him.

9.7 What is apparent is that professionals did not manage to establish much information about Mr B's background and his circumstances. The social worker harboured doubts about the credibility of K's explanation that Mr B was working away full time given the condition of the house and the fact he seemed to be around a lot of the time.

9.8 Equally professionals did not establish how K and Mr B had met which is evident from the speculation within the strategy meetings as to whether he had previously paid K to have sex. This speculation appears to have been prompted by the fact that K's mother had entered into a relationship with a former "client" and the thought was whether K was mirroring that behaviour.

9.9 Although professionals had concerns about the age gap, the social worker's rationalisation of this was that it was unlikely that K would be in a relationship that professionals would find straight forward given her early life experiences. More probing about the nature of the relationship would have been important given the national research on boyfriend / girlfriend being one of the models of sexual exploitation. [6]

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5 *Prior to 2014 the Inspiring Futures Team was a 16+ service with 6 social workers and 6 personal advisors. When it became an 18+ service in 2014, 4 of the social workers moved back into the locality LAC teams.*

6 *"Working with children who are victims or at risk of sexual exploitation: " Barnardo's model of practice:*

9.10 In addition to the concerns about the relationship with Mr B, there were continuing concerns about K's vulnerability to sexual exploitation which were reinforced by Mr B's claim that K was out "pimping with her mother'.

Assessment of risk post 18 years of age

9.11 Having regard to the above concerns, there was a significant change in professionals' perception of the level of risk once the LAC team ceased involvement and the Inspiring Futures Team became involved. During the latter's involvement there appears to have been no references to the possibility that she was a victim of sexual exploitation, or at any risk from her domestic arrangements

9.12 The team's perspective was that there was nothing about K's situation which would have raised any concern. This was because she was being seen at least weekly, she was engaging with the practical things she needed to do to access further training or employment, and was working towards getting her own accommodation. Their experience also was that K was an "exuberant" person whose presentation was always very good and her self-care skills excellent.

9.13 However as research findings on sexual exploitation have shown, the fact that a person presents and dresses well is not always a reassuring factor. This is because perpetrators often use gifts including money, clothes and jewellery to lure victims into exploitation, but also because victims will also seek to present well to disguise what is going on, often as a result of actual, or fear of, coercion.

9.14 A key point made by the Inspiring Futures Team which affects their involvement is the implications which flow from the change in legal status when children reach 18 years of age and they are able to make her own choices. This means that the level of support, advice and guidance provided depends on what the young person wants, or is prepared to accept. This seems to have been a factor following K's move to Rotherham in what the author views as the apparent passive acceptance by both the Inspiring Futures Team, and Project 3 practitioners, when they were unable to gain any information from K about where she was living and who her boyfriend was.

9.15 This resulted in insufficient challenge to K when she asserted that agencies did not have a need to know, or her insistence that any correspondence be sent to her grandmother's address. It does not appear that the Inspiring Futures Team took the opportunity to consider the pros and cons of wielding the leverage at its disposal in terms of withholding payment of the weekly allowance unless K was prepared to disclose where she was living and with whom.

9.16 It was only after K' death that the Inspiring Futures Team became aware that K's boyfriend was Mr B. It appears that this was not a possibility that had been considered before. With hindsight, the Inspiring Futures Team's speculation was that K's reticence may have been due to Mr B's children being subject to Child In Need processes in Rotherham, and that K did not want the team to be aware of her connection to him because of how this might be viewed.

9.17 It does not appear that any attempts were made to see if K's address could be obtained through contact with other agencies. The connection with Mr B might have been established if a more proactive approach had been adopted through enquiries with other agencies such as the local authority in Rotherham or to the police to see if they had any current information in respect of K given their active involvement prior to K's 18th birthday. During the SAR exploration of this issue, the perspective of the Inspiring Futures Team was that there was little indication that K was at risk which

would have justified making such enquiries given that legally K was an adult and could choose whether to share information.

10. ISSUES AROUND ENGAGEMENT

10.1 National reports consistently emphasise that securing effective engagement with victims of sexual exploitation is more likely when predicated on relationships with professionals they latch onto who can invest the time needed to allow victims to develop trust at their own pace. This might be a social worker, health or education professional or support worker.

10.2 Although the frequency of K going missing, and change of placements disrupted the opportunity for her to form relationships with residential staff, a positive was the continuity of involvement from several key professionals.

10.3 In addition to the continuity of the LAC nurse involvement, it was a major positive that K had the same social worker from coming into care. It is evident both from official reports, but also K's own comments, that they had a good relationship which K valued, and which was consistently cited as an important protective factor. K also developed a good relationship with the ETE co-ordinator who became involved in February 2018, and whom K used as a sounding board to test issues out before raising these with her PA. There was continuity of involvement of the Missing Persons Officer from SY Police, and also the CSE team who continued to visiting when K was placed outside of Doncaster.

10.4 However, despite this continuity, professionals struggled to secure K's full engagement with the support designed to protect her, and break through her evasiveness about her activities, whereabouts and people she was associating with both male and female. A recurring observation made by many professionals was that while on one level K was polite, friendly, and superficially co-operative, she would not offer more when pressed or would reject the advice and support offered.

10.5 A number of examples illustrate this. The LAC nurse's feedback from the December 2016 annual assessment was that K remained lying on the sofa, avoided eye contact, and just gave answers to questions that K thought the nurse wanted to hear rather than being prepared to talk about what was really going on for her.

10.6 This was also the experience of the CSE worker who visited K in West Yorkshire. K had previously sent a text to her LAC social worker saying that the latter's support was sufficient and she did not want input from the CSE team because it was pointless for people to try and give her advice when she already knew everything about CSE.

10.7 As observed previously, securing K's engagement became more challenging during K's final placement in Doncaster when in effect she was spending most of her time at her grandmother's home. When K returned to the unit to collect her weekly allowance, she preferred to spend most of her time in her room.

10.8 These examples illustrate the view shared by many professionals that in essence, K did not like being in care, and only engaged to a minimal level to get what she wanted. The perception was that K's way of looking at her situation was that she would be able to leave care when she reached 18 years of age, obtain her own accommodation, and be free to do just what she wanted.

10.9 This mindset only appeared to change after the independent advocate told K that she would only get her own accommodation if she worked with her key workers and social worker. This appeared to have the desired impact as K started to spend more time at the unit and engaged with the independence preparation work.

10.10 Following transfer of K's case. K received good support from the Inspiring Futures Team with a much higher level of contact than the minimum of every 56 days which the service uses as the measure for "meaningful contact". [7] However, although K would readily seek advice and support, frequently she did not the steps required to progress to secure these outcomes.

10.12 In part the high frequency of contact was because K needed to collect her care leavers' weekly living allowance until arrangements were in place for her to state benefits. A telling observation made by the Inspiring Futures Team service, was that once there was no longer a dependence on the financial support, K's contact with the service was "very much" on her own terms and when she wanted help with bidding for properties or referrals to training providers. In the light of what emerged during the SAR, the service acknowledged that although K had positive relationships with Inspiring Futures Team practitioners, she elected to keep parts of her life secret from them.

11. INTRODUCTION TO THE SAR LEARNING

Good Practice

11.1 It is evident that while K was a child, there was a relentless multi-agency focus on assessing the risks and unstinting efforts to provide her with the necessary support and protection. The analysis of the themes covered previously has highlighted a wide range of good practice:-

- the frequency and conduct of the strategy meetings;
- the continuity of involvement of key professionals;
- the persistence of practitioners in trying to secure K's engagement;
- the proactive response by the police to reports of K going missing;
- the use of abduction orders;
- the focus on K's health needs;
- the provision of advice and support around sexual health issues and exploitation;
- the level of support provided by the Inspiring Futures Team.

11.2 Many of these examples reflect the comprehensive guidance for professionals on tackling child sexual exploitation issued by Doncaster Safeguarding Children's Board [8] which in the author's experience is of a very high quality and one of the best seen.

11.3 Although it proved extremely difficult to protect K from child sexual exploitation, the analysis has shown this was not due to any gaps in individual agency input or adherence to multi-agency procedures. All possible options were tried including a range of placements which sometimes had a positive impact in the short term but could not be sustained because of K gravitating back to her family at every opportunity.

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7 *From July 2017 there are 46 recorded contacts with K including face to face meetings, telephone and text contacts and at least 15 email communications*

8 *"Professionals' handbook - tackling child sexual exploitation" - first published by DSCB in February 2016*

11.4 Achieving protection for any victim of child sexual exploitation is challenging, but in K's case or the more so because of the particular circumstances where her early experiences of neglect included exposure to sexual exploitation by her own family. This contributed to K's apparent reduced capacity to recognise, or acknowledge, the risks she faced from people she was associating with or situations she found herself in.

11.5 A further challenge, unlike many cases involving sexual exploitation, was that agencies never identified any information which suggested that K was linked to other victims or suspected perpetrators, and her name never cropped up in multi-agency meetings discussing other young people at risk.

The SAR Learning

11.6 The SAR findings have identified learning around the following seven issues:-

- use of language;
- consent to sexual activity;
- contextual safeguarding;
- use of the National Referral Mechanism for victims of human trafficking;
- information sharing in respect of adults;
- multi-agency arrangements to respond to sexual exploitation post 18 years of age;
- access to support for victims of sexual exploitation after transition into adulthood;

12. USE OF LANGUAGE

12.1 Doncaster's CSE handbook draws attention to the findings of previous serious case reviews in the UK where inappropriate use of language influenced professionals' perceptions, resulted in assessment of risks being under-estimated, and contributed to a systemic failure to protect.

12.2 For example the use of descriptions such as "prostitution" and "streetwise" can lead to inaccurate assumptions being made about children and their behaviour and can imply that they are choosing to make lifestyle choices. Streetwise implies that the person is able to understand the dangers they face, and protect themselves, when the reality of their situation is that they are vulnerable and exposed to situations they cannot control. Another consequence is that such descriptions will be seized upon by defence solicitors during criminal proceedings to try and undermine the credibility of victims.

12.3 The findings from this SAR indicate that professionals need to be reminded of the issues around use of language. There were several instances where inappropriate descriptions were used by professionals, or accepted without challenge, which referred to K being a "street worker as she had been seen out", being engaged in "prostitution", and "targeting" males in bars and clubs.

12.4 In exploring how to reinforce this message, the SAR discussions highlighted the complexities and challenges faced by professionals. For example, a fear of being criticised for using inappropriate language could lead to records not conveying the victim's situation sufficiently. It was acknowledged that there may be occasions when professionals may need to use terms which should usually be avoided, in order to describe the activity a person is caught up in and the risky behaviour. What is important is that any use of such terms, either verbally or in writing, is qualified, and accompanied by an explanation about the circumstances and causal factors.

13. CONSENT TO SEXUAL ACTIVITY

13.1 The inappropriate use of language sometimes to describe K's situation leads into the issue as to the extent both professionals and young people understand the concept of consent in respect of sexual activity which is abusive.

13.2 This is an important issue for all professionals, but especially police officers and the Crown Prosecution Service, when considering whether an offence has been committed. Although applying the law on sexual offences ultimately requires a view as to whether consent was sought or given, the issues around this can be complex. Factors to be taken into account include whether victims have been groomed through being given gifts, have been supplied with drugs or alcohol to break down their resistance, or have experienced actual coercion or threats of violence either towards themselves or people they are close to. Where coercion is a factor, it is important to consider whether the victim's mental capacity to give consent has been impaired.

Social Model of Consent

13.4 It is also important that professionals explore sufficiently with young people as to how the latter view the issues around consent, their understanding of the legal position, and the factors which have shaped their decisions.

13.5 Given all of the above issues, the SAR discussions identified the benefit of applying the "social model of consent" developed by Professor Jenny Pearce and the University of Bedfordshire. This provides a framework for understanding why children and young people might appear to be consenting to sexual activity that is abusive and / or unlawful. While their research is focused on children, the thrust of their approach is equally applicable to adults.

13.6 Underpinning the model is the view that all too often the focus has been on the behaviour of victims, and their capacity to understand and "give" consent rather than challenging when, and how, others take responsibility for obtaining consent. This can lead to victims being blamed inappropriately for apparently consenting to abusive sexual activity.

13.7 The model therefore emphasises the importance of assessing the impact of the pressures young people experience from the social and environmental contexts they find themselves in order to help establish if the child or young person:-

(i) is being groomed;

(ii) is engaging in survival sex because of financial pressures;

(iii) is being affected by the normalisation of sexual violence as projected through violent pornography or through peer group patterns that accept violence as part of everyday life.

In K's case, as explored previously, an additional factor was her being drawn into sexual exploitation by her own family.

13.8 The model also acknowledges that there can be an issue that the abuse is being overlooked or ignored through what it terms a culture of 'wilful ignorance', where professionals or others in contact with the child turn away from the truth of what is happening.

14. CONTEXTUAL SAFEGUARDING

14.1 Linked to the issues around consent, and given the nature of the risks K was exposed to, is the increasing importance of applying the concept of "contextual safeguarding" which was included for the first time in the 2018 update of "Working Together". [9] It is important to clarify however that the national guidance on this framework was not available at the time these issues were present in K's case.

14.2 First developed by Carlene Firmin of the University of Bedfordshire, [10] contextual safeguarding provides a framework to guide responses to a range of extra-familial risks that compromise the safety and welfare of young people. This explains that young people are vulnerable to abuse in a range of social contexts, for example from peer groups, through social media, and within neighbourhoods or schools.

14.3 The advantage of applying this framework is that it enables partner agencies that deliver, or manage, services in these settings, to design strategies and take action that provide essential complementary work to approaches focused on victims and their families. To support these approaches, a toolkit [11] is being developed and shared through the Contextual Safeguarding Network established by the University of Bedfordshire. This provides professionals with a "roadmap" for embedding contextual safeguarding in referral systems, assessment processes, and interventions – drawn from emerging models being worked up in the LB of Hackney [12] and other areas.

15. NATIONAL REFERRAL MECHANISM

15.1 The fact that there were many occasions when K was observed being driven off in cars, or asking to be collected from locations outside of the area, raises the question as to whether she was being trafficked. If that was the case, consideration would have needed to be given to making a referral through the National Referral Mechanism (NRM).

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9 *Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children – HM Government July 2018*

10 *"Contextual Safeguarding - An overview of the operational, strategic and conceptual framework" - Carlene Firmin – University of Bedfordshire - November 2017*

11 *Information about the toolkit can be found at www.contextualsafeguarding.org.uk/toolkit*

12 *Over the past two years the Contextual Safeguarding team at the International Centre (IC) have been working with the London Borough of Hackney to implement contextual safeguarding funded by the Department for Education Innovation Fund.*

15.2 The NRM involves a 2 stage process in reaching a decision as to whether there are grounds to conclude that a person is a victim of modern slavery or is being trafficked. If a "positive reasonable grounds" decision is made that this is the case, [13] victims can have access to independent tailored support commissioned by the Salvation Army [14] for a period of at least 45 days to begin to recover from their ordeal, and to reflect on what they want to do next. After further enquiries, a final "conclusive grounds decision" is made as to whether there is sufficient information to conclude that the person is a victim.

15.3 It is important to note that the consent of adult victims is required for a referral to be made. Where this is not forthcoming, but professionals have a reasonable belief that the person is being trafficked, they are required to submit an MS1 form to the Home Office [15] within a month of encountering a potential victim, unless there are exceptional circumstances. The form should be completely anonymised if the potential victim does not consent to their details being shared.

15.4 While the granting of NRM status does not in itself bring any immediate remedy or automatic protection against the exploitation, a key advantage is that consent is no longer a defence for perpetrators, and it opens alternative options for investigation rather than just sexual offences. It also bring the advantage of victims with NRM status not having to convince agencies that they are at risk of sexual exploitation, and if police officers encounter them in the company of adults, this should alert them to the need to consider the circumstances carefully in terms of whether exploitation may be an issue.

15.5 The fact that a referral was not considered in K's case underlines the importance of raising awareness of the NRM across the wider safeguarding partnership including professionals who are not classed as "first responders" [16] but may come into contact with people who have NRM status. This is now being addressed through the NRM being included in the Children's Safeguarding Partnership's training. This involves an exercise to enable participants to work through the issues around recognition, the referral process, and the importance of effective joint working with agencies commissioned to provide independent support.

15.6 As a result the review heard from the CSE team that the NRM is now being used quite frequently. A next step will be for the safeguarding partners to evaluate the impact these referrals have had in supporting victims, and whether referrals are being considered in all appropriate cases.

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13 *There is a 5 day target for this decision to be made on receipt of the referral*. *Support options include an entitlement to a place in safe house accommodation, access to legal advice, and independent emotional and practical help*

14 *Support in England and Wales through the NRM is currently delivered by the Salvation Army and a number of subcontractors. The Salvation Army will assess each potential victim to determine what support is most appropriate.*

15 *Notification of Potential Victim of Modern Slavery Form*

16 *A 'First Responder organisation' is, in England and Wales, an authority that is authorised to refer a potential victim of modern slavery into the National Referral Mechanism. These are listed in the National Referral Mechanism Guidance – Home Office updated 24 May 2019.*

16 INFORMATION SHARING IN RESPECT OF ADULTS

16.1 The learning around information sharing stems from the SAR exploration of the decision made by a Project 3 practitioner not to share her concerns about K's relationship with Mr B, and her behaviour during her attendance. This clarified that there was no evidence of actual risk which warranted taking the matter further. However, the SAR discussions also drew out some perspectives that in any event, an adult's wish to maintain confidentiality needs to be respected, and that this constrains professionals' ability to share information.

16.2 The ensuing discussion around whether, or when, information can be shared without consent suggests the need to provide a reminder of the guidance such as that published by SCIE, [17] the College of Policing, and the recent national guidance covering information sharing in children's cases. [18] These explain that a professional can reasonably override a person's decision not to give consent where other people may be at risk, a serious crime has been committed, or might be prevented, or where coercion appears to be influencing the decision not to give consent. In these circumstances, sharing information would be considered legally proportionate, and avoids the risk of data protection concerns being used as an excuse to withhold information.

16.3 In considering whether to share information without consent, it is important of course to weigh in the balance not just the above factors, but also the consequences of going against their wishes. This might result in a loss of trust and reduced engagement with professionals which could lead to an increase in the risks rather than diminishing them. Where professionals are uncertain on whether they are justified in sharing information, advice should be sought from their safeguarding leads and / legal advisors.

16.4 Given that there appears to be some continuing uncertainty around this issue, there would be value in the Safeguarding Adults Board seeking assurance that local information sharing agreements provide the necessary clarity, and provide a framework for swift information sharing without the need to negotiate access to information on an individual case-by-case basis.

17. RESPONSE TO SEXUAL EXPLOITATION POST 18 YEARS OF AGE

Introduction

17.1 The most significant areas of learning centre around the change in agency responses and multi-agency working which flow from the change in victims' legal status once they reach 18 years of age, and the challenges faced by both victims and professionals in trying to access support.

17.2 One immediate consequence in K's case was that no strategy meetings were held once K reached 18 years of age. This was at the point where the final strategy meeting in April 2017 had shared information which suggested that K was still at risk of being sexually exploited and that she may be at risk of domestic abuse. The meetings ended because there are no specific multi-agency processes within DSAB's procedures to address the risks of sexual exploitation experienced by adults.

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17 *"Adult safeguarding: sharing information" - Social Care Institute for Excellence (SCIE) January 2015*

18 *"Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers" – HM Government - July 2018*

17.3 It is important to stress however that these gaps are not unique to Doncaster, and reflects the fact that there is no national policy, or statutory framework, for responding to adult victims of sexual exploitation because their plight has in the past not attracted sufficient attention.

17.4 This has started to change over the last 2 years with increasing recognition nationally of the importance of supporting victims as they transition into adulthood, providing a safeguarding response, and ensuring the availability of support post 18 years of age. This has led to many safeguarding boards across the UK including these in their strategic priorities.

17.5 This follows the findings from a number of safeguarding reviews which have highlighted that sexual exploitation does not stop when children reach 18 years of age, and that while children may have become adults in the eyes of the law, their situation has not suddenly changed in terms of the risks they are exposed to or their ability to keep themselves safe. The 2018 Newcastle review [19] made the key point that perpetrators target vulnerability not age, and it is likely that extensive abuse of vulnerable adults is taking place across the country.

17.6 The NWG Exploitation Response Unit [20] continues to take the lead in raising awareness at national and local level. Their report in 2018 [21] captured the key issues and how these are being addressed at a local level. These messages were echoed in the strategic briefing on transitional safeguarding published by Research in Practice for Adults (RIPFA) in the same year. [22]

Transition Process

17.7 These reports describe how child victims can experience a "cliff edge" in terms of support as they enter adulthood which can see them fall through the gaps between children's and adults' services.

17.8 A key issue is the lack of robustness in the transition pathways for child victims unless they are "looked after" children where there are statutory responsibilities entitling them to continued support up to the age of 25 from the local authority. For other young people, who may have experienced high levels of trauma and harm, their circumstances and needs do not readily fall into the existing transition arrangements and referral routes into adult services – those provided by all agencies not just the local authority. This is despite research findings that have shown that access to ongoing mental health and therapeutic support for victims moving into adulthood is crucial to aid their recovery.

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19 *Joint Serious Case Review Concerning Sexual Exploitation of Children and Adults with Needs for Care and Support in Newcastle-upon-Tyne - Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board published February 2018*

20 *Formerly known as the National Working Group (NWG) for sexually exploited children and young people*

21 *"Sexual Exploitation - the journey into adulthood - it does not stop because you turn 18": Summary narrative of responses from the NWG Electronic Working Group on Transition – (Child) Sexual Exploitation and Transition between Children's and Adult's Services. – published 2018*

22 *"Mind the gap – Transitional safeguarding – adolescence to adulthood" – Strategic Briefing published by Research in Practice for Adults (RIPFA) 2018*

17.9 A contributory factor can sometimes be that transition planning starts too late, with the result that a victim's future needs are not clearly identified, and approaches are not made sufficiently early to adult services to explore the options for providing future support. Any lack of engagement with adult services at an early stage can result in professionals being unsure about what different services can offer and the referral criteria / pathways for accessing these.

17.10 Increasingly, concern is being voiced by a range of professionals nationally that a strict interpretation of the eligibility criteria set out in the Care Act 2014 is too often resulting in adult victims of sexual exploitation not qualifying for services because they are judged not to have care and support needs. This can result in young people who are experiencing various developmental or mental health difficulties being denied support unless they have previously received a formal mental health diagnosis.

17.11 National reports [23] have shown that there are often difficulties in achieving transition for young people from child and adolescent mental health services (CAMHS). While CAMHS provide support around a wide range of mental health issues, AMHS tend to focus on services for people with severe and enduring illnesses such as psychosis or severe depression. A further difficulty is that commissioning of CAMHS and AMH services often takes place within different frameworks which can result in care pathways being developed separately.

Safeguarding response to adult victims

17.12 The eligibility test as to whether a person has care and support needs can also affect whether adults receive a safeguarding response. Although legislation and national guidance sets out responsibilities to respond to allegations of abuse and neglect in respect of adults and children, there are some crucial differences in the underpinning policy approach which can result in a very different system response more governed by the age of the service user rather than risk.

17.13 The children's system has a clear focus on welfare, emphasises protection of children from harm and promotes risk management approaches. Whereas for adults, current legislative frameworks places an emphasis on promoting wellbeing and that adults have the right to make informed decisions about their own lives, even if those decisions appear unwise.

17.14 The decision whether to seek or initiate a safeguarding response is also affected by the issues around consent. In contrast to the position in respect of a child, consent would usually need to be sought from an adult victim because of the fundamental principle enshrined in the Mental Capacity Act 2005 that it must be assumed that they have mental capacity to make decisions about their care and protection. However, as outlined earlier, professionals need to be alert to the possibility that coercion or other factors become so significant that they have a serious adverse impact on how this 'right / ability' is exercised, and victims may not be able to make free informed choices about their safeguarding needs.

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23 *For example see "Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services" Joint Commissioning Panel for Mental Health (JCPMH) February 2013*

The Doncaster position

17.15 The SAR discussions resulted in agreement that the current local position reflects many of the issues summarised above. Anecdotal evidence was received from the CSE team about a number of high risk cases where it has not proved possible to identify future support. This leads to practitioners being anxious about these children's future and facing the dilemma as to what further steps they can take to protect victims as the time for the ending of children's services involvement approaches.

17.16 Where transition to adult services has been achieved, this has largely been due to the good will and creative solutions of some teams in finding ways of providing support because of an ongoing concern to safeguard young adults at risk. However, the processes followed, and arrangements made, are not currently set down in a formal pathway or covered by any governance framework.

18. PARTNERSHIP WORKING IN RESPECT OF ADULT VICTIMS

18.1 The absence of a national framework also means that there are gaps in the current local arrangements for partnership working in respect of adult victims of sexual exploitation. There are no agreed local processes which mirror the robust partnership arrangements that exist to protect child victims as required by "Working Together" and associated national guidance which in Doncaster results in extensive use of strategy meetings and the Protecting Vulnerable Young People Panel (PVYP) [24] to consider individual children's cases.

18.2 There is also no statutory requirement for the police to engage in wider partnership working in respect of adult victims of sexual exploitation. This means that currently there is no forum which replicates the work of the THRIVE meetings [25] which are held as part of the CSE partnership arrangements to co-ordinate action to disrupt and pursue perpetrators. These are chaired by the police who regularly share the updated Police Local Problem Profile to provide the most up to date picture of CSE related issues in Doncaster and a direct comparison with other South Yorkshire authority areas.

18.3 A further issue which limits police involvement is that sexual exploitation of adults is not an offence in itself, unless it involves trafficking. Therefore, unless an offence is reported, the police are unable to commence an investigation. Where victims are brought to the police's attention but no criminal offences are apparent, there is no requirement for continuing police involvement although the police do signpost victims to local statutory partners where they can seek assistance.

18.4 Finally, a significant organisational difference is that although SY Police has a specialist CSE team to deal with children's cases, there is no dedicated sexual offences team for adults. Investigations are therefore carried out by appropriately trained local CID officers unless these involve trafficking in which case these are passed on to the Human Trafficking and Modern Slavery Team.

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[24] *The Protecting Vulnerable Young People Panel (PVYP) considers cases of children at risk of CSE and / or who go missing on a frequent basis.*

[25] *The Police hold fortnightly THRIVE meetings (Threat, Harm, Risk, Investigation, Vulnerability & Engagement) for tactical managers within partner agencies.*

19. PRIORITY ACTIONS TO IMPLEMENT THE LEARNING

19.1 The recommended priority actions to implement the key learning are centred around 4 inter-related themes:-

- Evaluating the effectiveness of transition processes for children at risk of sexual exploitation as they move into adulthood;

- Challenging the different perceptions of risk which currently exist in respect of children and adults victims, and raising awareness of the need for a safeguarding response to continue after children transition into adulthood;

- Strengthening partnership working to identify, and respond, to sexual exploitation of young adults, and extending the range of specialist support;

- Reviewing the governance arrangements for directing work in relation to sexual exploitation to ensure these cover both children and young adults and provide a joined up approach.

Transition

19.2 In response to the Children and Families Act 2017 which extended support for care leavers until age 25, DCT has strengthened its arrangements around transition for care leavers. Since 2017 the Inspiring Futures Team now becomes involved prior to looked after children reaching their 16th birthday which avoids the problem of late transfer to the team that occurred in of K's case.

19.3 However, given the experiences shared by the CSE team, it will be important to now move from anecdote to firm understanding of the local issues around transition for victims of sexual exploitation. The production of an informed position statement will identify what further action is required to strengthen the existing protocols covering transition, and the multi-agency processes to consider individual cases. This is an approach that has been applied in some other areas [26] as highlighted in the NWG and RIPFA reports.

19.4 In addition to gathering full information from the CSE team, there would be value in conducting a multi-agency audit of children's cases. This should be both in relation to those which are at still at the transition planning stage, but also a retrospective examination of cases of children who have recently attained 18 years of age in order to establish how effectively the transition process worked, and to what extent risks, and future support needs, were identified and met.

19.5 As part of this work, it will be important to explore how the Care Act 2014 eligibility criteria are being applied in respect of victims of sexual exploitation. This should be both in terms of the response to safeguarding concerns raised, and the extent to which the prevention duty in the Care Act is being used as a means of developing more flexible approaches to help young adult victims access support to assist recovery from trauma, or to address other mental health or substance misuse issues.

19.6 The Review heard that there is already some work around transition which is being led by the Public Health Department. Given the findings from this SAR, it will be important that this, or a parallel process, establishes the specific position in respect of those at risk of sexual exploitation.

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26 *Sheffield Transition Project; East Sussex*

Response to risk of sexual exploitation after children transition into adulthood

19.7 A key priority for the safeguarding partners to address is what appears to be a significant difference in how risk is viewed in respect of child and adult victims of sexual exploitation. This will first require a major awareness raising programme across, and at all levels of, the adult and children's safeguarding partnerships, to shift the current mindset and reinforce the key messages in the NWG and RIPFA reports that the risk of sexual exploitation does not stop when a child reached 18 years of age.

19.8 Within this awareness raising it will be important to identify what multi-agency arrangements are required to co-ordinate protective interventions where it is judged that a young adult is still at risk, and to enable information to be shared to support action to disrupt and pursue their alleged perpetrators.

19.9 The SAR heard that work around this has already started, and that discussions are well advanced around the advantages of extending the existing Multi Agency Safeguarding Hub (MASH) dealing with children's cases to create an all age MASH. This would enable professionals in the MASH to access, and use, all available information held by agencies in respect of both children and adults involved in a referral, to inform decisions on the appropriate response. It will also mean that decisions can draw on professional expertise covering both adult and child issues.

19.10 Reference was also made within the SAR discussions to a number of existing initiatives in Doncaster which some workshop attendees suggested would be possible forums where individual cases could be discussed to co-ordinate support and provide a pathway into appropriate services. These included:-

- Vulnerable People Panel (VPP)
- Community MARAC (CMARAC)
- Complex Lives Alliance / Complex Lives Team
- Amber Project supporting "street sex workers"

19.11 With the exception of the latter, the explanatory documentation regarding each of these does not refer specifically to victims of sexual exploitation in its list of target groups, although it is quite possible that some victims will come to their attention because of their presenting difficulties such as substance misuse or homelessness.

19.12 This may explain why not all participants at the SAR workshops were aware of the detailed operation of these schemes and / or whether cases of adult victims would meet the criteria for referral. Given this lack of awareness, it will be important to explore the potential for these to promote multi-agency support for adult victims, and ensure this is communicated across the wider safeguarding partnership.

Support for Adult Victims

19.13 Research has shown how adverse experiences during childhood leaves victims vulnerable to further exploitation, and can have long term consequences terms of their experiencing poorer outcomes across the lifespan. Difficulties can include the impact on their mental health, their parenting ability, and their increased chances of becoming homeless, and / or drawn into the criminal justice system.

19.14 The Review findings suggests that there are limited support options available following initial involvement with the Sexual Assault Referral Centre (SARC), or to provide therapeutic support for adults experiencing some form of post traumatic stress disorder (PTSD). A further issue which emerged from the SAR discussions is the difficulty some services have in securing victims' engagement because these are

not sufficiently flexible. National reports have highlighted that the availability of outreach services has proved effective in achieving more effective engagement with young people whose lives are often chaotic due to the nature of the exploitation they are experiencing, which can make it difficult for them to access clinic based services.

19.15 A first step therefore will be to map existing support that is available, both in the public and voluntary sector, and to clarify the referral pathways. The findings would then support the development of a commissioning strategy which sets out affordable options to fill any gaps identified to ensure the development of services which reduce the risk of exploitation of vulnerable people in the longer term.

19.16 This could include the development of a business case for a specialist support service for young adult victims of sexual exploitation which would mirror the support available to children through the CSE team. The NWG and RIPFA reports have highlighted the positive impact that developments such as the Newcastle Sexual Exploitation Hub [27] are having. A key element of any such proposal would be to ensure that access to support includes victims who do not have care and support needs as defined within the Care Act 2014.

19.17 In making this recommendation, it is acknowledged that this will be challenging given the difficult financial climate facing all agencies which makes it difficult to undertake any work that is not statutory. However, Doncaster's own studies have already identified the significant financial cost to the health, social care and criminal justice systems if timely support is not provided to address victims' needs which often results in more costly intervention later. Investing in preventive and recovery work has the potential to avoid this.

Governance Arrangements

19.18 Providing the necessary strategic oversight to progress the suggested priority actions will require governance arrangements which reflect the fact that the issues around transition into adulthood for victims of sexual exploitation is a shared agenda for the adults and children's safeguarding partnerships, and requires a joint approach across the age divide.

19.19 Doncaster is well placed to achieve this through its new safeguarding partner arrangements which were implemented from September 2018 in response to the requirements of the Children and Social Work Act 2017. [28] This resulted in Doncaster's LSCB becoming the Doncaster Safeguarding Children Partnership (DSCP).

19.20 The recognition that there are a number of cross cutting issues which affect both children and adults is reflected in the revamped Chief Officers' Safeguarding Overview Group which provides the strategic leadership and oversight for both adult and children's safeguarding. In addition, by virtue of its membership, close links are ensured with other strategic partnerships including the Children & Young People's Partnership, the Community Safety Partnership, the Heath & Wellbeing Board, and Team Doncaster.

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27 *The Newcastle multi-agency service supports both child and adult victims of sexual exploitation and modern day slavery in recognition of the way perpetrators were targeting individuals regardless of age.*

28 *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (2018), the statutory guidance for the Children and Social Work Act 2017, requires the safeguarding partners – Local Authority, Clinical Commissioning Group, and Police – to publish local safeguarding children arrangements.*

19.21 To complement the high-level strategic nature of the Chief Officers' Group, the Children's Safeguarding Partnership Board and Safeguarding Adults Board, which sit beneath it, have a more operational and tactical focus. These now meet on the same day in one meeting that has separate children's and adult's agendas with a joint agenda in between. The decision to have the same independent person to be convenor of the Chief Officers Overview Group, the Safeguarding Children's Partnership and Chair of the Safeguarding Adults Board is facilitating the identification of mutual areas of business.

19.22 In launching these changes, it was acknowledged that the revised arrangements would need to evolve over time. A further development recommended from this SAR is to take the joint working a stage further by extending the role and membership of the Child Exploitation and Missing Sub Group [29] which has been retained within the new arrangements and has been given a wider remit encompassing all forms of exploitation of children.

19.23 The recommendation is that this group's remit be extended to become a cross age joint strategic group to co-ordinate activity and development in respect of both adults and children victims of sexual exploitation. In making this recommendation it is acknowledged that the group's effectiveness might be undermined if its remit becomes too wide, and the SAR heard that this was one factor for this option being rejected during the work on designing the new safeguarding partner arrangements.

19.24 Consequently, the SAR is proposing that the extension of the age range to be covered would be restricted to young adults up to the age of 21 years. This would ensure that there is a multi-agency focus on the crucial period during children's transition to adulthood, and the immediate period thereafter where a continuing safeguarding response and access to support is vital to minimise the onset of longer term problems.

19.25 A key stakeholder in the discussions around this proposal, and consideration of the reporting lines for the revised sub group, will be the Safer Stronger Doncaster Partnership [30] because of its role to strategically plan, commission and oversee services that tackle crime and disorder, address drug and alcohol misuse, and deal with anti-social behaviour.

19.26 To ensure the effectiveness of the proposed revised group, it will be essential that there is a shared vision of its purpose, clear terms of reference, and its membership includes services that have regulatory powers which can support the police and contribute to the "pursue" element of the exploitation strategy - for example services covering licensing, trading standards, and parks management.

20. MULTI AGENCY RECOMMENDATIONS

1. The joint Doncaster Adult Safeguarding Board and Doncaster Safeguarding Children Partnership (DSAB and DSCP) in consultation with the Safer Stronger Doncaster Partnership, should consider extending the remit and membership of the existing Child Exploitation and Missing Sub Group to include strategic oversight of arrangements to address the risk of children being victims of sexual exploitation after they transition into adulthood and up to their 21st birthday.

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29 *The remit of the Child Exploitation and Missing Sub Group includes child sexual exploitation, child criminal exploitation and county lines, trafficked children and children missing from home and care.*

30 *Doncaster's title for the statutory Community Safety Partnership*

2. The DSAB and DSCP, in consultation with the Safer Stronger Doncaster Partnership, should satisfy itself that:-

   - there is a shared understanding across the safeguarding partnerships that young adults may continue to be at risk of sexual exploitation after they reach 18 years of age, and that this requires consideration of a safeguarding response;

   - there are multi-agency processes in place to share information, assess risk, and co-ordinate interventions to protect victims, including action to disrupt and pursue alleged perpetrators.

3. The DSAB and DSCP should request its statutory partners to provide a position statement on the effectiveness of transition arrangements for victims of sexual exploitation, and the extent to which they are able to access support to meet their assessed needs as they transition into adulthood. The findings should be used to inform any necessary work to:-

   - clarify transition pathways and eligibility for services;

   - ensure that the prevention duty set out in the Care Act 2014 is being applied in a flexible way which supports the identification of future support needs;

   - map existing services and develop a commissioning strategy to extend the range of support.

4. The DSAB and DSCP should seek assurance that professionals across the adult's and children's safeguarding partnerships have the necessary awareness of the law and complex issues in relation to consent to sexual activity, taking account of sexual exploitation and wider coercive and control issues.

5. The DSAB and DSCP should seek assurance that risk assessments in response to possible sexual exploitation identify the circumstances without recourse to language which could imply that victims are making lifestyle choices.

6. The DSAB and DSCP should seek assurance that professionals across the adult and children's safeguarding partnerships have the necessary understanding of the processes, and potential benefits, in respect of the National Referral Mechanism for victims of human trafficking.

7. The DSAB and DSCP should seek assurance that its Joint Information Sharing Protocol sets out the circumstances in which information can be shared without an adult's consent, and that quality assurance processes are provided through the Caldicott Guardians [31]within organisations.

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[31] *A Caldicott Guardian is a senior person within a health or social care organisation whose role is to ensure that personal information about those who use its services is used legally, ethically and appropriately, and the highest practical standards are maintained for the handling of patient-identifiable information between the NHS, councils with social services responsibilities and other partner organisations.*