

## **Serious Incident Learning Review Summary SILR 11C**

### **Reason for the Review**

The Serious Case Review Sub Committee discussed the child's case on 05/08/2011, following a referral made by the Youth Offending Service. It was agreed the criteria was not met for a Serious Case Review but that the case would benefit from a Serious Incident Learning review.

### **Review Process**

All agencies provided reports and chronologies based on the information available to them in respect of the victim and perpetrator. A review meeting was held on 17/02/2012 in which all involved agencies attended. It was agreed that a final report and action plan would then be provided to the Serious Case Review Sub Committee.

### **Agencies Involved**

- Children's Social Care
- Derbyshire Police
- Derbyshire Youth Offending Service
- NHS Derbyshire County
- Derbyshire Traveller Education and Support Team
- Ethnic Minority Achievement Service

### **Summary of the Case**

#### **Child Victim**

The child was the sixth of ten children in a travelling family, the family had not been known to children's social care but the Traveller Education Service from another area had been involved for a number of years as the family had resided there on and off over a long period of time. The family had been described as warm, stable and supportive and had been co-operative with services.

When the child left primary education the family opted to home educate which had been a pattern in this family. This work was monitored termly by the traveller education service. In September 2012, the education liaison officer was informed the family would be travelling and so the younger children in the family would not be attending school. Further enquiries were made in November 2010 and father confirmed the family were still travelling the service was not aware the family were in Derbyshire at the time.

In March 2011 the service was informed the younger children were back in school.

In May 2011, the service visited the family and were informed the child had been assaulted and that the child had ran away some months ago 'to get married'.

## **Partner**

The boyfriend was also from a travelling family, he first came to the attention of services aged 11 due to possession of a firearm. He has a number of convictions for offences of public order, theft including motor vehicle theft. He was convicted of sexual assault on a female and this assault was on a female leisure centre worker. He was sentenced to a 12 month Youth Rehabilitation Order, he was excluded from the leisure centre for 3 months and was required to undertake 120 hours unpaid work. During the assessment he was assessed as low risk although an AIM assessment was not completed.

At the time of the pre-sentence report, he was living with his sister-in-law and her children as well as his girlfriend these living arrangements were not assessed. During the assessment by the Youth Offending Service, no concerns were raised in relation to drug or alcohol use, or mental health problems. He had little formal education his family opting to home tutor him. He admitted to not being able to read or write. He became involved in the family scrap business.

## **The Couple's Relationship**

It is not known exactly when the relationship commenced, although at the time of the incident March 2011 the child stated she had been in a relationship with him for the past 7 months. The child reported that the relationship had always been violent, both physically and sexually and that he exerted a level of control over her in terms of who she saw and deprivation of money.

## **Agency Involvement**

The child had presented herself to hospital on two occasions, in 2008 and 2010 complaining of abdominal pain, she was discharged with painkillers on both occasions. She had attended a GP on a number of occasions for the treatment of acne. In 2010 the child attended the Emergency Department in a hospital in Derby with gastro-intestinal problem and was discharged to Mother's care. In August 2010 the child attended the Emergency Department in a neighbouring hospital with a possible Urinary Tract Infection.

There was a brief involvement with the Derbyshire Traveller Education Service in September 1999, shortly after this time the family returned to another area where they had previously lived.

The Ambulance Service were called to the address on a number of occasions on one occasion the call related to the child who had abdominal pains and was taken to the neighbouring hospital. No other call outs were related directly to the couple.

The three agencies that had the most contact with the couple were the Youth Offending Service, Children's Social Care and Derbyshire Police. In all three cases there were missed opportunities to intervene and offer protection to the child.

The child attended the pre-sentence appointment with the Youth Offending Service where it was stated that the couple were married. No enquiries appeared to have been made despite the child being 15 years of age at the time. Risk factors relating to the offence were not considered and checks were not made with children's social care.

In August 2010 the police responded to a report that the partner was 'killing his wife' the police did not view this as a safeguarding referral despite the fact the child was 15 years of age. No action was taken to make further enquiries about the child's living arrangements although a referral was made to children's social care. The decision was made to complete an Initial Assessment however this was not carried out and the case was closed. The partner was not charged for the assault on the child and no medical was undertaken.

In September 2010 an anonymous referral was made to children's social care that drugs were being used in the sister-in-law's home. A contact was opened but later closed as it was felt that the child was a traveller of no fixed abode. The next contact with the family was the serious assault in March 2011, this was appropriately managed the child received support and her ex-partner was convicted of rape and assault and remains in custody serving a 12 year prison sentence.

### **Contact with the Victim**

The victim has been seen on two occasions and has reported that the violence began one week after she had been living with the ex-partner. The victim described feeling let down by agencies who knew she was 15 at the time. She said that her ex-partner's mother knew of the violence but did nothing; she described being assaulted in the presence of her then partner's family. She described leaving the partner on 3 occasions but returning. It was noted that the victim appeared vulnerable and younger than her age.

### **Missed Opportunities**

- A failure by the Traveller Support Service to establish her whereabouts when she was travelling. This may have identified her vulnerabilities and pinpoint when the relationship had begun.
- The failure of the Youth Offending Service to assess the relationship. The nature of the index offence should have triggered concerns about any relationship including the contact the partner was having with relative's children. Lateral checks should have been completed with the police and children's social care.
- The failure of the Youth Offending Service to complete an AIM assessment in relation to the perpetrator.
- In August 2010 the police received a referral regarding an assault on the child, this was viewed as domestic violence, given the child was 15 years of age at the time it should have been viewed as child abuse. A referral was made to children's social care but no joint investigation was carried out.
- Children's social care failed to follow procedures following the referral by the police a section 47 enquiry should have been undertaken. The second contact one month later failed to focus on the child who had been assaulted.
- The health visitor working with the wider family failed to see the child's vulnerabilities.
- No agency considered the child who was effectively in a Private Fostering Arrangement; this is a secondary to the issue of safeguarding.

## **Summary and Analysis**

The child was a vulnerable young woman who has suffered physical, sexual and emotional abuse whilst in a relationship with the perpetrator. The review has highlighted a number of missed opportunities to intervene and safeguard the child. It is clear that both families knew of the violence but did nothing to intervene.

The cultural issues in this case are significant and all agencies accepted the cultural norms which were presented to them without question or further assessment. This is particularly the case in terms of the 'marriage' and no scrutiny was applied in relation to this issue.

## **Recommendations**

### **Ambulance Service**

- Further enquiries to be made in relation to calls being identified by name as well as address, this is particularly important when there are safeguarding concerns.

### **Youth Offending Service**

- Lateral checks with other agencies to be made on all household members where PSR reports and ASSET assessments are being undertaken.
- AIM Assessments to be undertaken in relation to all sexual offences.
- The service should put systems in place to assure itself that all staff is aware of the requirements of the Derby and Derbyshire Safeguarding Children Procedures.

### **Derbyshire Police**

- Systems to be reviewed to ensure that all patrol; officers are aware of the need to instigate Derby and Derbyshire Safeguarding Children Procedures where there are assaults on young people under the age of 18 years.

### **Traveller Education Service**

- Consideration to be given to more robust enquires being made when the whereabouts of children and young people are not known.

### **Health Visiting**

- Enquiries should be made of all household members, including young people.

### **Hospitals**

- The named and designated professionals should ensure that systems are in place to establish who attends presentations and appointments with children and young people.

### **Derbyshire Safeguarding Children Board**

- Discussions should take place with the Derbyshire Traveller Education Service in order to formalise advice and training input in relation to the cultural issues highlighted in this review.
- Reminders to be issued to all agencies in relation to Private Fostering Regulations.
- Audit arrangements and outcomes by other agencies to be reported to the DSCB.
- The missing person's protocol should ensure that the living circumstances of young people who are missing are properly assessed.