Child A - Local Child Safeguarding Practice Review.

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The purpose of this review

The alleged interfamilial sexual abuse of A was notified to the Stockport Safeguarding Children Partnership and after a rapid review meeting it was determined that an independent author would be appointed to conduct a Serious Case Review into the circumstances surrounding the events leading to the allegation.

The Purpose of the review was to identify any local learning regarding our current practice and areas that could be developed to prevent future incidents.

A multi-agency chronology was developed to analyse the information and key events.

Alongside this, a practitioners' event was held to explore key lines of enquiry to identify learning.

Family views have also been gained as part of the review process.

The review explored services engagement with the family from May 2017, when A first alleged she had been sexually assaulted to April 2021, when the second allegation was made.

Subject of the review: Young Person A

Significant others
Sibling – Young Person B
Sibling – Young Person C
Father - Adult D
Step-Mother – Adult E
Grandfather – Adult F
Mother – Adult G

Methodology

The review was started by an independent author and finalised by the Safeguarding and Learning Head of Service. The practitioner event was facilitated by the Independent Chair of the Safeguarding Children Partnership (SSCP)

There were 27 practitioners involved, and they represented the following agencies.

- Youth Justice Service
- GP Practice
- Independent Reviewing Officers
- Safeguarding Training
- Complex Safeguarding Service
- Children's Social Care
- School Nursing
- Mental Health team
- Greater Manchester Police
- Stockport Clinical Commissioning Group
- Safeguarding in Education
- Community Health Services.

The practitioners were split into two breakout rooms where facilitators guided the conversation, and the practitioners were asked to consider the following:

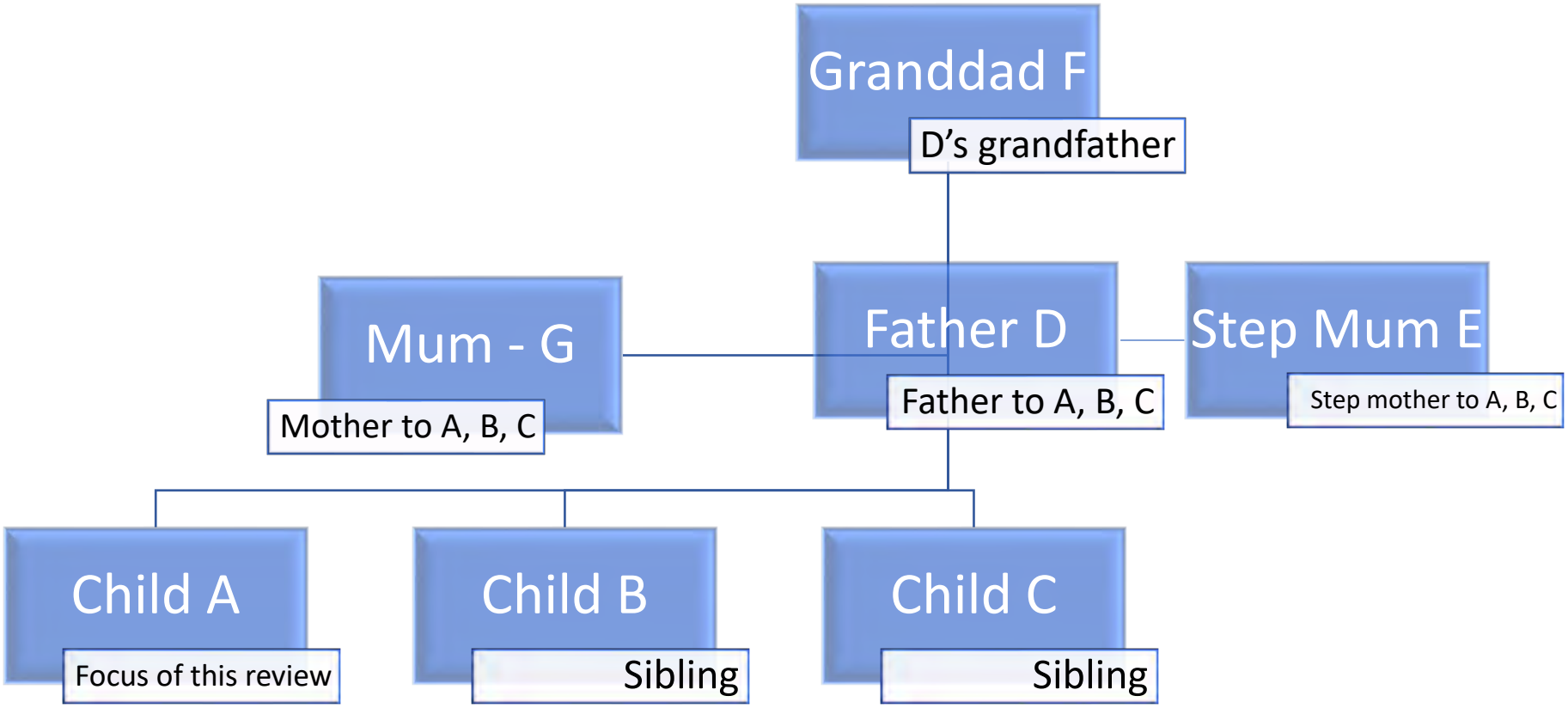
- Are there any issues that arise from this information for you? (Pen Pictures and Chronology of significant events)
- Has anything changed in your agency since 2017 that may lead to a different intervention for A or B?
- How are you supported when working with parent(s) who are professionals?
- Are there any barriers in this area of practice for you/your agency and what would help?
- When assessing sexually harmful behaviour in a family, what is important when approaching the assessment?
- Multi-agency information sharing continues to be a barrier in many cases where reviews take place. What do you think is the reason for this and how can we support any change in this as a partnership?

Key Lines of Enquiry

The review seeks to explore key lines of enquiry identified from the combined chronology:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the SSCP;
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
- Examine the effectiveness of case handovers/transfers, information sharing and working relationships across borders;
- Examine the involvement of other significant family members in the life of the child, and family support provided to the subject family;
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify any actions required by the SSCP to promote learning to support and improve systems and practice.
- Examine the effectiveness of the local safeguarding children arrangements including Team around the child / Early Help processes and arrangements for managing difference of opinion.
- Examine the effectiveness of support for victims of Child Sexual Abuse.
- Examine the effectiveness of arrangements to manage young people who develop harmful sexualised behaviours towards others.
- Consider the effectiveness of family support in cases where high levels of supervision has been identified for the protection of other children in the family who would otherwise be considered at risk of significant harm.
- Examine the role of school in recognising, assessing and supporting children exhibiting concerning or sexualised behaviours.
- Consider the effectiveness of the local arrangements for proving quality “Keep Safe” work for individual children who are at risk of or have experienced sexual harm.

Family Tree


Granddad F
D's grandfather
Mum - G
Mother to A, B, C
Father D
Father to A, B, C
Step Mum E
Step mother to A, B, C
Child A
Focus of this review
Child B
Sibling
Child C
Sibling

About the child / their key issues

G -Mum (35)
- Domestic abuse
- Mental ill-health
- Substance misuse issues
- Assault

D -Father (39)
- Domestic Abuse
- Cognitive ability
- Criminal activity

A – (13) Focus of the review
Child of G & D
- Early Childhood neglect
- Sexualised behaviours
- Hurts self
- Domestic Abuse

B -Brother (15)
Child of G & D
- Mental Health difficulties
- Domestic Abuse

C - Brother (8)
Child of G & D
- Domestic Abuse

E -Step Mum (45)

F –Granddad (83)

Significant Family History

- Between 2005 and 2019, mum, G, is listed a victim of domestic abuse. She is also noted as an offender between 2005 and 2017 for a series crimes; production of cannabis, s.39 assault, possession of a weapon, public order and racially aggravated damage.
- Between 2005 and 2014, D, the children's father, is listed as a perpetrator of 10 domestic abuse offences involving G, the children's mum. He has also been a victim of criminal damage and theft of a motor vehicle
- B and C are listed in 4 of the domestic abuse incidents and A is listed as a secondary subject to 6 of them

Pen Picture – Child A

A is now 13 years old.

A now lives with her mum, G. At the time of the incidents she was living with her dad, D and step mum E. A has two siblings, B (16) and C (8)

A struggled with being able to see/ spend time with both parents and how this will affect the other one.

A loves both of her parents and her step mother, E who she has a strong relationship with.

A likes the typical things a teenager is interested in and she's described as a pleasure to work with.

Pen Picture – Child B

B is 16 years old and has aspirations for his future education and career.

B has a close bond with his grandfather F and spends a lot of time with him. B has struggled in his relationships with dad, D, and step mum, E.

B does have a good sibling relationship with C and it is felt that this is due to C being in B's life from being a baby. B does not see A as much of a sibling mainly due to her coming into his life during his junior years. B has found it difficult to form a sibling bond with A.

B also struggles with his mental health. This has been ongoing for some time.

Chronology of Significant Events

Date	Event
January 2016	B was referred to HYMS (now known as CAMHS) after experiencing visual and auditory hallucinations. B was prescribed medication and the following month he was referred to an alternative service and closed to HYMS. There were further referrals made to the CAMHS service for B on numerous occasions as he continued to struggle with his mental health.
August 2016	B reported being bullied at primary school which caused him anxiety.
May 2017	A (9) told a professional in school that B (11) had orally sexually assaulted her. This led to involvement from GMP and Stockport Children's Social Care. B was arrested for the alleged offence and GMP completed an investigation. The family didn't support criminal charges and the report crime was finalised as No Further Action (NFA)
May 2017	B was attending High School and there was a lack of information shared with them in relation to the allegation and living circumstances following the report of abuse from A.
May 2017	B's GP was unaware of the allegation of sexual abuse made against him. The GP continued to receive information from the paediatric team and CAMHS in relation to B's appointments and investigations into his hallucinations and headaches.

Chronology of Significant Events

Date	Event
June 2017	The SW assessment concludes. The SW also makes reference to Brook Traffic Light tool which would classify this as a "red" incident for B requiring intervention. The assessment concludes it was likely that A has been sexually assaulted by B and that risk remains. There was a safety plan in place for how the family would supervise and monitor B and A to safeguard her. The family were closed to social care at this stage. Schools were asked to complete work with the children in relation to sexually harmful behaviour and to offer support.
June 2017	A was seeing her GP for a number of concerns for her welfare; She was vomiting several times a day and reported struggling with toileting. A said she wishes she was dead. It was reported that A hits her head on walls and she is not meeting her educational targets. (The GP was not aware of the sexual abuse allegation)
October 2017	October 2017 Police were called when mother, G, refused to give the children back to father, D, after spending the day with them. D has residency of the children therefore they were returned to his care (no onward referrals made)
February 2019	School noted some concern for A that she was using sexualised language beyond her years with other children.
September2019	GMP responded to a domestic abuse incident at G's home with a partner who had assaulted her. Record reads that children do not live with G therefore no onward referrals made.
January – February 2020	A's School noted a number of concerns for her behaviour in school. Low-self esteem, becoming disruptive in class and concerns were raised by another parent that A is often seen outside her house talking to strangers. They were worried for her safety. The school also reported A talking about not wanting to live any more and becoming upset.

Chronology of Significant Events

Date	Event
March 2020	There were continued reports of A's behaviour deteriorating in school and she wasn't completing homework.
April 2020	Home based online learning due to COVID 19 pandemic.
July 2020	Concerns were raised in school in relation to A offering to send indecent images of herself to other pupils in school.
September 2020	A started in high school. Concerns were raised that she had drank alcohol. Teachers talked to her about this and A spoke about her feelings of abandonment saying that her mum abandoned her years ago for 'drink and drugs'. Additional 1:1 support was put in place for A at school. Information was shared with the school safeguarding team.
October 2020	A was admitted to hospital after experiencing blood stained vomit. This was put down to gastritis. This continued to happen, alongside abdominal pain, over the next few months. A's GP sent off blood tests and referred her to a specialist team in January 2021.
March 2021	E had a telephone consultation with the GP reporting concerns for A's behaviour. Gave background of early childhood experiences. E reported her worries for A's difficulties with regulating her emotions - hits self, damages personal property, cuts things, breaking items at home and with no identifiable reason. Struggles with friends. School not offering any formal support due to COVID. A referral was made to HYMS (now known as CAMHS) for A (there was no mention of former sexual abuse allegation)
April 2021	A's disclosures of further sexual assault are reported to GMP by E.

Issues to consider

The Voice of the child

- It was not evident that A was being listened to by professionals around her, as there were several key times when she was asking for help. Especially in the education setting.
- The children's voices were not strong within the assessment to understand their daily lives and lived experiences.

The Social Work Assessment

- Lack of exploration of the children's family history led to a limited assessment focusing on a single issue rather than considering previous events experienced by the children.
- The father did not appear to be present in the assessment and much of the communication was with the children's step-mother.
- The children's birth mother was not included in the assessment.
- The children's father's role and history of being domestically abusive was not reflected in the assessment to consider how this may have impacted upon the children.
- Was there an assumption that stepmother was able to safeguard without enhanced support due to her employment as a professional in a safeguarding profession?
- There is a need to give staff stronger support and guidance on working Sexually Harmful Behaviour e.g. co-working with another worker so there is two social workers and not one working with the family.
- Lack of curiosity in exploring the children's history and formulating a chronology meant that the response was focused on a single issue rather than considering the previous events experienced by the children holistically.

Information Sharing.

- It was noted that, here an issue can be seen as minor by one agency, this can be escalated into a more significant risk when shared with similar issues from other agencies.
- There are elements of good practice, however there is a need to invite wider agencies to meetings where these are circulated, such as GPs and school nurses.
- It is important that professional curiosity is initiated with regards to earlier life experiences, particularly when services have been accessed in a different Local Authority; safeguarding will override consent with regards to information sharing.
- Sharing of information directly with GP's and to also gain their information about the children.
- Sharing of and quality of information when transitioning schools.

Issues to consider

Criminal Investigations

- The fact that there was a criminal investigation taking place as a barrier to supporting B in 2017. It appeared to cause lack of clarity around what information can be shared.
- The length of time criminal investigations take to complete leads to further impact on the victim, A in this case and the family. The outcome of the investigation may impact the future intervention for the family.
- A child's ability to take responsibility and talk about what has happened in incidents of sexually harmful behaviour and abuse maybe influenced by the severity of the allegations and implications within the criminal justice system. This will also be influenced by legal advice and parental views. Lack of admission from a young person in situations where there is a lack of other evidence to proceed with a criminal charge, or in this case where parents did not support proceeding with prosecution, may therefore limit what action can be taken in terms of use of the AIM assessment process.

The role of the birth mother

- The issue of who had parental responsibility was not explored within the intervention.

The health system.

- There is an assumption that a referral to Health as a single service is assumed to be sufficient, when there are several different services and NHS Trusts; information needs to be shared or gathered from all agencies so that a holistic picture of the family is gained.
- It should be considered whether there is a sound understanding amongst agencies of the organisational structures of Health provision across the workforce. For example, informing the GP of will not mean CAMHS will have access to the same information as they do not share the same recording system for patients. Information also needs to continue to be shared with Health agencies.

Issues to consider

Sexually Harmful Behaviour (SHB)

- Are professionals armed with the right tools in order to work with families around sexually harmful behaviour?
- Considering the role of co-working when there are challenging conversations to be had.
- The importance of using an evidenced based assessment tool to assess the risk of sexually harmful behaviour. i.e. the AIMS* assessment where good quality training is provided to complete this.
- An effective multi-agency assessment with a sound hypothesis of a situation can allow for more effective and targeted support.
- Are agencies familiar with the GM protocol and AIM processes for responding to sexually harmful behaviour to ensure the right people are invited to initial AIM strategy meetings and child protection conferences.
- The complexities of working with a child who has reported SHB and does not admit this and where this is not evidenced via a Police investigation.
- The understanding of the SHB Policy was lacking as this was not followed during the time that Social Care worked with the family. For example the Policy states that two workers should be allocated and that the Youth Justice Service should be present at the strategy discussion.
- There was also complexity with how Children's Social Care support families where a criminal investigation is ongoing and SHB is present. Investigations can take a significant period of time and or not lead to a conclusion. With the allegations finalised with no further action by GMP, this led to no one being able to evidence the allegations A made against B.

Parents Views

Birth Mother - G

- G's first and foremost views were centered around communication and information sharing. G said "I wish someone just told me" in relation to A's first disclosure of sexual abuse in 2017. G was upset that she didn't know what was going on for her child and wanted to be able to support her.
- G was upset that she was not included in the initial Social Work Assessment and felt as though this was a priority as to her knowledge D does not hold formal legal parental responsibility for the children. G raised the issue of ensuring that all parents with Parental Responsibility are part of the Social Work assessments.
- It was felt that the Social Work assessment did not consider the family history and the domestic and sexual abuse that G suffered that was allegedly perpetrated by D. G said "no one would want me involved to erase the history, like it didn't happen."
- G shared that child B witnessed some of the abuse she suffered and feels as though this will have impacted upon him. It was suggested that this could have contributed towards his alleged sexually harmful behaviour towards A.
- G shared her view that information was not successfully shared or transferred when the children went from living with her in one borough to living with their father, D, in another area. G felt that this information and history should have been shared to ensure that it was known as she felt that D continued to pose a risk to the children, and this was not considered. At the time G was spending time in hospital due to her mental health declining and this was the catalyst for the children being in D's care.

Parents Views

Birth Father, D and Stepmother E

- D spoke about his involvement in the Social Work assessment in 2017, where he cannot recall meeting the Social Worker in person. D said that he spoke to the worker on the phone, and he agreed for E to be the point of contact for the assessment.
- E felt as though the service offered by CAMHS was poor. She reported how after many referrals no treatment was provided for B which was worrying giving his recurring mental health difficulties, hallucinations and anxiety.
- E described information sharing as a challenge and how the children's school would not share information with each other. She felt this was important as it has continued to be a theme and information sharing protocols could be improved.
- In relation to the support provided by services in 2017 to help D and E mange the safety of the children within the home from any potential sexually harmful behaviour, E acknowledged that they were more vigilant in the home and that had slipped more recently as time went on.
- D and E did not recall a safety plan being discussed with them and they didn't have a hard copy of anything like this.
- E stated that she only met the assessing Social Worker once and D was not there on this occasion. Following this visit the case was closed.
- E wasn't sure if her job within the safeguarding profession impacted the actions of the Social Work assessment or not. E felt as though it was likely this was why she was not given thorough advice and support on how to manage sexually harmful behaviours. She believes there was a sense that she would 'know' how to ensure the safety of the children within the home; because of her profession.
- D's learning difficulties were not considered in the Social Work assessment, and he felt that this impacts his ability to engage in work like this as he doesn't understand what is being said without E's support to interpret this

System changes since 2017

- The team around the school is more mature and embedded within practice and this would have led to more robust information sharing and joint planning.
- Information sharing between the Stockport Children's Social Care and Mental Health Services has improved. There are now Mental Health Practitioners based within the Multi Agency Safeguarding and Support Hub (MASSH) leading to a better triangulation of information with partners.
- A trauma informed approach is being embedded across Stockport with multi agency training being rolled out across the public and voluntary sector.
- Since 2017, work across borders with other Local Authorities has improved, there is also a more effective use of chronologies and work with families is now stronger through use of a trauma-informed approach.
- Most schools now use electronic means for record-keeping, this allows for more timely and accurate extraction and sharing of information when required.
- There has been a focus on practice in relation to sexually harmful behaviour. This has included learning circles and a task and finish group to improve practice and tools available for practitioners working with sexually harmful behaviour.
- In 2019 AIM* training was delivered to a number of Social Workers and Youth Justice Officers within Stockport Family. There is also now a desktop AIM's assessment that the Youth Justice Service can complete with children who display SHB when there is no conviction or criminal investigation. This would however require the child to be honest about this so that meaningful work can take place.
- *Assessment intervention and moving on – farmworker for assessing and intervening with young people who display sexually harmful behaviour [The AIM Project – The AIM Project]

	Learning
1	The influence of the voice of the child and understanding of her experiences is not a focus in the record keeping within the education system. For example, when A is asking for help and saying statements like she wants to die; no one is asking her why or being curious about the reason for her unhappiness.
2	The safety plan in place for parents to ensure there was no possibility that B could abuse A again was not risk assessed robustly. There was too much reliance upon parents to continue to do this without additional support or direct work.
3	The importance of looking at the family history, exploring and understanding historical information within the social work assessment was a factor. The assessment focused on a single issue, narrowing the scop of the assessment to understand the children's lives and experiences holistically.
4	It was evident that not all professionals understand the complexity of the health information recording system, leading to information not being shared with the right part of the system.
5	Sharing information continues to be problematic and is reliant on the right agencies being invited to and attending meetings to be able to receive or share information.
6	There is a need to understand how a criminal investigation might impact on working with a family leading to a delay to move forward with interventions
7	The role of the nonresident parent was not fully considered by practitioners, leading to information being missed and the parent not being included in the assessment.
8	Practitioners are not always equipped with the right skills to support young people who behave in a sexually harmful way leading to appropriate interventions not always taking place.
9	The knowledge, understanding and use of the processes and policy around sexually harmful behavior needs to be further embedded in practice.