Learning from the case – Child R

A summary of the case reviewed:

This partnership review concerned the serious sexual assault of a vulnerable person by an adolescent.

The young person was born to a young mother, who had a second child within a couple of years. Both children's early years were marked with referrals for poor housing conditions, lack of parental oversight and a concern from professionals and family regarding his mother's mental health and parenting skills.

The young person's father had a conviction for a schedule 1 offence and the sibling's father was the subject of allegations of sexual abuse made by both children. Both universal and specialist services had serious concerns about physical and sexual abuse of the children for a number of years. The police were regularly involved with the family for a range of anti-social behaviours and child care concerns. Extended family members also shared their concerns with professionals.

The earliest reports of physical abuse affecting the young person and sexual abuse of his sibling had been received by the time the young person was four years old. By the time he was seven his behaviour was reported to be aggressive and necessitated a referral to child and adolescent mental health services. His behaviour progressed to become sexually and physically abusive towards his sibling and peers. Concerns continued that he was the victim of similar abuses from the adults linked to his family. This resulted in two periods of child protection planning, the first of which began when the young person was nine and during the second period the case entered pre-proceedings. He was accommodated in a residential unit as a young teenager for a year, then rehabilitated home for a short time until his mother requested that he be accommodated again. The young person received several years of specialist assessment and treatment for young people with sexually harmful behaviour before the offence was committed.

How was learning achieved?

This partnership review was practitioner-focused. A chronology of events was produced but written reports were not requested in advance of meeting. Two meetings were run by the lead reviewer with the different practitioners who had been involved with this family. They ran through key points in their involvement with the family. The aim was to learn the following:

- were there mistakes in individual professional judgment or actions?
- how effective was the family–professional interaction?
- were there any difficulties with systems, including recording and information-sharing, in managing the case?

- was there independent oversight of the case?
- how well had professionals worked together in assessment and longer term work?
- how well had professionals worked together in response to incidents and crises?

This approach generated the learning detailed below. The family also contributed to review and provided their perspective on work undertaken with them.

Themes in common with other case reviews in Oxfordshire

- **Neglectful parenting** over a protracted period leading to serious developmental harm including exposure to **sexual abuse and physical injury**
- **Effort and attention paid to engaging mother** led to the child's timescales being lost
- **Insufficient assessment of men** in the family as protective or risk factors
- **Safeguarding young people who are adolescents** with high risk behaviour and highly complex needs
- **Individual incidents not collated to provide a full overview** of the safeguarding risks

Four learning points for managers

- **Supervision:** the structure for supervisions should be reflective and ensure that the practitioner is making decisions based on all information and focus is maintained on the child
- **Management:** ensure that all practitioners are using all available tools especially the 'neglect tools' Awareness of Neglect | Oxfordshire Safeguarding Children Board and plan actions in a SMART way. Ensure practitioners are trained in responding to neglect, physical injury and sexual abuse.
- **Escalate:** if risks are not reducing, despite interventions, escalate to senior manager and make use of legal panel/ complex case panel according to criteria met.
- **Support:** debrief difficult events when there have been hostile or difficult interactions with family members.

Five action points for practitioners

- Ensure assessment, decision-making and intervention are **structured and directed towards safety and improved outcomes within the child's timescales**
- **Understand sexual abuse and collate signs and symptoms to evidence risk** – don't rely on formal disclosures to initiate protective action
- **Access supervision** and use it to drive your work forward

- **Attend multi agency training** and follow the training schedule for the OSCB so you are up to date Training | Oxfordshire Safeguarding Children Board
- **Scope all available information** from all sources prior to any decision making and consider contingency plans

Key messages for inter-agency learning

Working well together includes confident challenge and professional curiosity within the multi-agency arena supported by:

- Shared tools and frameworks
- Understanding of roles and responsibilities of others
- Effective recording of practice, to enable the sharing of relevant information

If you do one thing, take the time to…

- To find out more about the role and remit of an agency that you frequently work with. Do you understand how they work? Are you getting the best out of joint working with them? Are you able to constructively challenge their practice?

Training

If this case resonates with you the OSCB recommends:

- Dealing with dangerous, difficult and evasive parents
- Child Sexual Development, healthy and Unhealthy/sexually Harmful Behaviours

Look it up on Training | Oxfordshire Safeguarding Children Board

OSCB learning

The OSCB also learnt about process from this review – future reviews should have clear objectives, faster timeframes and better strategic commitment. A new learning, improvement and quality assurance framework has been developed to address that: see www.oscb.og.uk