

This summary briefing presents the key findings/recommendations from the audit and is aimed at managers and practitioners working with children and families. Please share this briefing with colleagues

### Background

- Working Together to Safeguard Children (2015) requires Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- The aim of the LSCB Multiagency Familial Sexual Abuse (FSA) audit was to understand the quality of safeguarding practice, compliance and to seek assurance that there was consistent application of the LLR LSCB multi-agency safeguarding procedures and threshold, and partner agency identification and response to cases where FSA is a theme. A critical part of the audit was to capture any learning which support improvement in practice aimed at strengthening safeguarding for children.
- The audit report will be submitted to the LSCB Performance, Analysis and Assurance Group (PAAG).

### Definition

Working Together to Safeguard Children 2018 defines **sexual abuse** as:

*'Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.'*

According to the [Children's Commissioner: Inquiry into Child Sexual Abuse in the Family Environment \(November 2015\)](#), *'Child Sexual Abuse refers to all forms of contact and non-contact sexual abuse, including Child Sexual Exploitation (child sexual exploitation), intra-familial sexual abuse, sexual abuse in institutional settings, and online sexual abuse'*. The inquiry focused on *'child sexual abuse in the family environment'* and was defined for purpose of the inquiry as:

*'Child sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member'*. This is a broad definition.

The NSPCC identified two types of abuse called contact abuse and non-contact abuse and also signs, indicators and effects in which children who are sexually abused may stay away from certain people, show sexual behaviour that's inappropriate for their age and have physical symptoms. For further information see: <https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/>

### Methodology

This audit was conducted as a Leicester, Leicestershire and Rutland (LLR) LSCB audit. The audit tool, scope, number of cases and timeline were confirmed at an LLR LSCB auditors meeting on 13.11.2018. Five cases were audited for Leicester and therefore this was a qualitative audit, which provided a snap-shot of the quality of multiagency safeguarding practice. This briefing relates to the findings from the Leicester cases. The five cases were identified by Children's Social Care and Early Help Service.

The scope of the audit was the last 6 months. The audit was to be completed by January 2019, and a thematic discussion meeting took place on 09.01.2019. The following agencies participated in the audit

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Agencies	Number of cases audited (not all cases were known or within the scope for all agencies)
Leicestershire Police	1 (out of the 5, 1 was audited. 1 was mostly out of scope and 3 out of scope)
Children Social Care and Early Help Service	3 out of the 5 (in relation to EH 2 cases were out of scope and 3 not known)
Schools/education settings including providers	4 (one out of the five was not currently in education)
GP (CCG)	4 (out of the 5)
UHL	1 (4 out of the 5 were not known or out of scope)
LPT	3 (out of the 5)
UAVA	2 (3 out of the 5 were not known)
NPS	1 (4 out of the 5 were not known)
SSTOP	-
CAFCASS	-
Turning Point; DNLRC; ASC	0 (not known)
DNLRC	0 (not known)
ASC	0 (not known)

### Further Information

<http://llrscb.proceduresonline.com/>

[LSCB Website](#)

[LSCB multiagency audit summaries](#)

Can you hear me videos: <https://vimeo.com/165429690>

## Key points

Referrals: were timely. Practice was mainly compliant, robust and included a summary of history. There was timely intervention where required, preventing drift/delay. However, in one case, a young child had been omitted from the referral, and therefore a need for practitioners to ensure that unborn and other children are always mentioned in the referral.

Assessments: were timely and there was multiagency presence. Recommendations were appropriate, the assessment continuous through various processes and there was a good level of communication between practitioners. There was no delay in progressing safeguarding arrangements. A range of assessment tools were used to assist assessments but could have been stronger. The involvement of parents including absent parents was required, as was clarification of information between agencies to reduce any discrepancies and for agencies to share information from assessments instead of waiting for core groups for an update.

Voice of the child/lived experiences: a range of methods were used by practitioners. Children's views were understood, including non-verbal and young children's cues. This helped to make plans more specific. However, a need for training for new staff was suggested. It was noted that there is information about obtaining the views of children and understanding their lived experience for example the video 'Can You Hear Me?', which is a collection of short films written by young people exploring their experiences with professionals and how they felt they were treated and listened to, and the final scripts are performed by young actors available at <https://vimeo.com/165429690>.

Plans: had elements of being SMART. There was multiagency attendance, and agencies worked well together at Core groups. Actions were clear, worked well, plans reviewed regularly and changed or adapted as required. Practitioners knew what to do if there was deterioration or disengagement. Conference and case notes were recorded quickly, information sharing agreed and reviews were timely. However, in one case (audited by LPT) it was not made clear to the practitioner that the plan had to be kept active and open. The practitioner was not clear of her role in the action plan and did not document it. The Parent-link worker in the school re-worded plans so that these were accessible to the child and parent. However, it was identified that plans need to be easily understood by children, parents and those with learning disabilities. The number of agencies involved with the family needs to be considered. Children Social Care to ensure that GPs are invited to meetings, their attendance recorded accurately, and the decision/plans are sent to them. It was suggested that the Safeguarding Unit, Children Social Care consider adding a front sheet to plans, records of conference meetings stating the decision and next meeting date. It was suggested that a meeting where practitioners/professionals involved in a case could offer and/or received support would be useful.

Supervision/management oversight/leadership: agency standards were followed, other than in one case audited by LPT where the supervision pathway was not followed - has been raised internally. Within Children Social Care Signs of Safety approach in supervision is being embedded.

Record keeping: genograms and chronologies were recorded in the cases audited by Children Social Care, however, the quality was variable. Whilst there was evidence of safety planning some were not scanned in; visits were recorded but children not seen within timescales; evidence of progression of plans, but not always present on the system. The school recorded the conference minutes when received, but when minutes are received later it could cause conflict with parents if there are any inaccuracies. It was suggested that schools and agencies challenge any inaccuracies in conference minutes to ensure accuracy. It was noted that currently it is not a possibility to get systems used by agencies (such as Liquid Logic, CPOMS, SIMS, etc.) to 'talk' to each other for agencies to access information.

Safeguarding: there were no safeguarding escalation issues identified during the audits or audit discussion, and procedures were followed by practitioners.

Life chances improving: school attendances improved for the children involved. There was reduction in potential safeguarding, although in one case the child was subject to repeated child protection.

Equality and Diversity: should also include diversity of conditions. Learning disability was considered and responded appropriately by the school. The right level of support and diversity/ethnicity was recorded by LPT. Diversity and ethnicity is recorded in the GP system, however, the auditor is to remind GPs to ask patients about diversity/ethnicity and to record this. Two out of the five cases were known to UAVA. The social worker (in one case) did not refer the child to UAVA for support as they thought they would not be able to communicate with the child. This had been escalated by the agency and the auditor. Practitioners should refer appropriately to agencies to ensure that children and families receive the relevant support. In another case, the social worker had allowed the school to guide them on how to involve the child. This was important as schools know how to communicate and engage with children and can support other practitioners to do so.

## Overall conclusion and suggested actions

1. Across the partnership there is a much improving picture in relation to the work around understanding the lived experience of the child/obtaining and 'hearing' their voice. A variety of methods are being utilised. The involvement of children (and families) in safeguarding planning should continue, and documents shared with them should be accessible to them.
2. Referrals and assessments have been good and timely – this has worked well. However, practitioners should ensure that all children, including unborn children are mentioned in the referral. Practitioners (including Social Workers) to refer appropriately to agencies (such as UAVA) for children and families to receive the relevant support.
3. The difference made to the children (whose cases were audited) is that the risks were being managed well.
4. There was some evidence of life chances improving as a result of intervention, although it was also noted that whether these do as anticipated is of a worry.
5. A professionals meeting, where professionals/practitioners involved in the case/meeting can access support that they might require, needs to be considered and happen.