Leicester LSCB Multi-Agency Audit: Familial Child Sexual Abuse

This summary briefing presents the key findings/recommendations from the audit and is aimed at managers and practitioners working with children and families in Leicester. 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.
- Safeguarding children who experience poor emotional wellbeing and/or mental health was identified as an area in which the LSCB required assurance, to better understand compliance and to seek assurance that there was consistent application of the LLR LSCB multi-agency safeguarding procedures and threshold.
- The audit wanted to seek assurance that partner agencies were appropriately identifying and responding to the needs of children experiencing poor emotional wellbeing and mental health, and to capture any learning needs which support improvement in practice aimed at strengthening safeguarding for children. The audit included accuracy of case details, underpinning this was the 'Voice of the Child' and compliance to procedures.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB audit group, which has representatives from the following agencies:

Leicester City Council	Leicestershire Partnership Trust (LPT)	Leicestershire Police
LSCB Office	University Hospitals of Leicester (UHL)	Clinical Commissioning Group (CCG)

Cases were identified by Children Social Care (CSC) for audit and out of these, ten cases were selected by the LSCB Office and CSC for the audit. Although the cases were identified by one agency, the intention of the audit was to evaluate the multi-agency response to meeting the needs of and safeguarding the children in these cases.

Ten cases were audited by CSC, nine (out of the ten) by Leicestershire Police were known to them, nine by the GPs (CCG), five by LPT, one by National Probation Service (two were known to Probation Providers. Out of these cases, one was a current case and the other current to CRC. Two cases were out of scope and one was known to the former Leicestershire and Rutland Probation Trust). One case was audited by UHL (in three cases UHL had no contact during the audit period and the six remaining cases were out-patients or in the emergency department, where no action or safeguarding involvement was identified). In some agencies not all the cases were known or within the scope of the audit.

Further Information http://llrscb.proceduresonline.com/ LSCB Website
LSCB multiagency audit summaries

Definition

Working Together to Safeguard Children 2015 defines **sexual abuse** as:

'Sexual abuse 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 (including via the internet). 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 (see information at: NSPCC) and also the following signs, indicators and effects in which children who are sexually abused may stay away from certain people, show sexual behaviour that is inappropriate for their age and have physical symptoms:

Stay away from certain people	***Show sexual behaviour that's inappropriate for their age***	***Have physical symptoms***
• *they might avoid being alone with people, such as family members or friends* • *they could seem frightened of a person or reluctant to socialise with them.*	• *a child might become sexually active at a young age* • *they might be promiscuous* • *they could use sexual language or know information that you wouldn't expect them to*	• *anal or vaginal soreness* • *an unusual discharge* • *sexually transmitted infection (STI)* • *pregnancy*

Key Findings/learning

- Compliance with procedures was variable. There was lack of understanding of People Posing Risks procedure and assessment tools, and local procedures were not followed consistently in all the cases and agencies. In one case, a child was used as an interpreter and practitioners need to be aware that this is inappropriate.
- Case Recording is still an issue. Language and religion were not consistently recorded in all the cases, although UHL and the Police found that correct details were recorded in the cases they audited
- Obtaining the 'voice of the child' and considering their lived experience was not consistent in all cases and across the partnership. In one case, regarding the child's lived experience, their cultural heritage and parentage of both parents and any impact was not considered fully. The child's lack of engagement was identified as an issue. However, practitioners should consider the child's situation, environment and contributing factors and pull this together with what the child is saying (or not) to consider what life is like for the child, to consider potential risk and protective factors to information safeguarding planning.
- Referrals were appropriate in most of the cases. In one case NPS notified CSC of the father's release from prison resulting in action for staff within NPS to check with CSC of involvement where an offender is appearing for sexual offence regardless of whether it is non-contact. In one case, had CSC considered the risk to sexual abuse in an earlier referral, it could have resulted in earlier intervention to safeguard the child
- Assessments were completed within the time scales by CSC and NPS. However, pre-birth assessments were not conducted by CSC in two cases of unborn children (one due to not receiving information in time and the other an initial referral was not appropriately responded to, resulting in the assessment not progressing until a further referral was made); identifying that the needs of the unborn children were not considered initially.
- The father in the case audited by NPS was involved in the assessment process. Overall, greater awareness of involving and engaging with father/step fathers in assessments is required by practitioners.
- There was evidence of good challenge and escalation by practitioners and managers. In one case, there was challenge to CSC relating to risk to an unborn child not immediately assessed and in another the original judgement was overturned by the Service Manager.
- A lack of genograms was identified by LPT in the cases they audited, and CSC identified that the quality of genograms and chronologies need improving. The use of relevant research and tools was not consistent across all cases and agencies. Where relevant CSE, THRIVE and DASH tools were used by the Police and CSC found that research was used well in some cases, but not all as there was limited reference to tools used in some. It was identified that *"There is a need for consideration of how to ensure PPRC [People Posing a Risk to Children] risk assessment are completed with reference to adults convicted of possessing indecent images of children".*
- Overall the children were registered under the appropriate category. In six of the cases, the children were on Child Protection Plans under the category of sexual abuse. A further two were on a Child Protection Plan under the category of neglect and in one of these, according to auditor, the risk of sexual abuse should have been included alongside neglect for the Child Protection Plan.
- Safety and contingency planning, contribution from agencies and risk being addressed was evident in most of the cases, although the need for consistency in quality and robustness of Plans was identified
- Good multi-agency working was evident, but this was not consistent across all the cases and partnership. Issues relating to administration (meetings not held in time, meetings not recorded and notes not circulated) and contribution to multi-agency meetings was identified in a small number of cases.
- A lack of GP attendance/contribution was identified in some cases, despite invitations to conferences. In one case, a persistent health issue identified by LPT, and a range of health issues noted in the GP audit, but there was a lack of correlation/analysis between both agencies of why this was the case, although the risk of sexual abuse appeared to be documented.
- Management and supervision was evident, but this needs to be more robust in some cases. The lack of participation of schools and education settings in the audit was noted.

Recommendations: Partner agencies ensure that:

- Their single agency audit activity is to include evaluation of whether accurate details (including all demographic information) is recorded in the cases files audited and to provide assurance (at Quarter 4) to the LSCB Performance Analysis and Assurance Group of the outcomes.
- They encourage their staff to use the relevant procedures, including the LSCB multi-agency safeguarding procedures, People Posing Risk to Children guidance and procedure, risk assessment tool(s) and research (including where adults are convicted of possessing indecent images of children) to inform their assessments and safeguarding practice.
- They improve practice within their agency in relation to considering the lived experience of the child, including evaluation on the understanding of the child's environment and factors relating to diversity, to inform safety planning.
- They ensure that suitable interpreters are made available where required and that children are not used.
- They encourage relevant staff within their agencies to be aware of, and engage with, fathers, including step fathers, in the safeguarding process.

Recommendations: To improve multi-agency working:

- GPs and relevant practitioners consider and analyse all the information available to them to make connections between the information held by different services/agencies to get a fuller picture of the child's health and inform safeguarding of the child.
- GPs to contribute to the Child Protection Conferences. This would allow GPs to be informed of the information shared by agencies, be alerted to safeguarding concerns and update their records accordingly.
- NPS to make sure that there is liaison between NPS staff and Children's Social Care.
- Children's Social Care to improve practice in responding and recording referrals appropriately to make sure that the response is appropriate and timely, and avoid delay in the child protection system. The quality of genograms and chronologies is improved. Multi-agency meetings are robust, recorded and records are circulated to the relevant practitioners/agencies, and plans are SMART and robust.