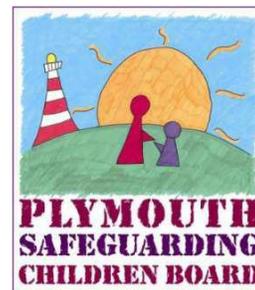


**PLYMOUTH SAFEGUARDING CHILDREN BOARD
MULTI-AGENCY CASE AUDIT
20 FEBRUARY 2017**



EXECUTIVE SUMMARY

THEME: HARMFUL SEXUAL BEHAVIOUR
PANEL DATE: 20 February 2017

1.0 Introduction

Working Together 2015 states that Local Safeguarding Children Boards should “quality assure practice, including through joint audits of case files, involving practitioners and identifying lessons to be learned”. In response the Plymouth Safeguarding Children Board (PSCB) operate a Multi-Agency Case Audit Process, which aims to provide it with evidence of safeguarding practice across partner agencies. The audits are qualitative in nature and aim to provide a window on the system to illuminate practice strengths and areas for development across the partnership.

2.0 The Audit

In response to a Serious Case Review the PSCB developed and published guidance on working with HSB. This MACA aimed to review practice around HSB following the implementation of this guidance and to consider any up to date practice learning that would need to be included in a planned update of this guidance.

Five cases were selected at random from all children currently open to Plymouth City Council Children Young People and Families Service, with a child in need code of HSB at the point of referral. Consent was obtained from four families for their case to form part of the audit.

3.0 The Process

Seven lead auditors from key agencies participated and facilitated the audit for their agency. These included Children Young People and Families, Devon & Cornwall Police, Plymouth NHS Hospital Trust, National Probation Service, SEND/Education, NSPCC and a representative of the Young Safeguarders. Livewell South West CIC, Barnardo’s and the Community Rehabilitation Company were unable to participate.

A summary sheet of each audit was requested from all lead auditors. Each case audited involved parental/child feedback. The panel gathered on 20 February 2017 where three of the four cases were discussed and learning identified.

4.0 Summary of Good Practice

- Most of the cases showed evidence of good multi-agency working. There was some excellent work to co-ordinate the team around the child, some good assessment work and evidence of identifying and managing risks.
- Diversity issues relating to learning difficulties, disability and historical backgrounds had been managed sensitively.
- Evidence of good quality research by Devon & Cornwall Police
- There was evidence of sustained and proactive professional challenge and commitment by the Virtual School in one case.
- There was good evidence of agency challenge and use of escalation processes.

5.0 Summary of Identified Learning and Themes

- Two of the 4 cases involved the young person having made historical sexual abuse allegations.
- Three of the 4 cases identified that the young person had previously had access to on-line pornography.
- All 4 young people have a learning difficulty and/or mental health diagnosis.
- Two of the 4 young people had access to a Barnardo's advocate.
- Use of AIM2 assessments is crucial in guiding and putting together care plans.
- There have been some good assessments, but the thread going through to care-planning, thus ensuring plans are effective, needs to be identified and strengthened.
- Understanding the importance of the full family history is essential in care planning.
- Acknowledgement that risk of overcrowding within home can increase the risk of HSB.
- In one case there was the recognition that a criminal process can be appropriate where a child has committed a criminal offense, although this is set against not wishing to criminalise the young person. Appropriate levers were affected to safeguard the child and ensure his safety and those of others.
- A consistent relationship with one allocated social worker aids trust, understanding of the full family history, and effective care planning.

6.0 Multi-Agency Case Audit Recommendations

- That all learning on individual cases is picked up by the lead auditors, who should take accountability for ensuring required casework actions are completed.
- Lead auditors must also take accountability for ensuring any identified areas where practice or systems in their agency require improvement are escalated/addressed.
- Learning from the audit, including good practice, should be disseminated within agencies by lead auditors and across the partnership via PSCB mechanisms.
- The learning should be considered within the LAPP sub-group and any implications for practice development or training progressed via the LAPP work-streams.

Whom	When
All	31.03.17
All	31.03.17
All/BSM	30.06.17
LAPP	06.06.17

- The task and finish group reviewing the HSB guidance should consider the practice learning and ensure the guidance addresses areas where practice is not sufficiently robust.
- The Safeguarding Business Manager should review timetabling and processes for identifying cases and seeking consent from families, and should circulate the summaries in advance to panel members.
- The PSCB should consider supplementing this audit with a further deep dive into the 4 cases to consider the quality of interventions, risk management and therapeutic work in detail.
- Learning and Communities department should consider how best to ensure that communication and management oversight between schools and off-site provision takes into account any risks/vulnerabilities arising from a young person's HSB.
- It is recognized that, for CYPFS, placing a child involves balancing a range of competing needs. However the process should be reviewed to include a conversation with learning and communities about potential school provision to inform the decision making.

Whom	When
BSM	25.05.17
BSM	10.05.17
LAPP Chair	31.03.17
L&C	31,03,17
CYPFS	31.03.17

7.0 Secondary Review Deep Dive

The Chair of the PSCB Learning and Professional Practice Group convened a further deep dive into four cases to consider the quality of interventions, risk management and therapeutic work in detail. The task was assigned to and undertaken by Senior Consultant Social Worker, NSPCC and a Team Manager from Children Social Care. Key records were scrutinised and information cross-referenced with the Research in Practice HSB Audit Tool¹, and findings from the HSB Serious Case Review (NSPCC 2017)² were applied.

7.1 Conclusions

The Deep Dive Audit identified emerging themes which echoed findings from the HSB Serious Case Review (NSPCC 2017):-

- Responding to individual incidents of HSB can become the focus of professionals' attention, rather than looking at patterns of behaviour and the reasons behind it.
- Professionals may not understand the seriousness of HSB so they do not always make appropriate referrals or follow-up.
- Sometimes a child's risk to others can overshadow any risks they are being exposed to. This may mean that the child is not supported appropriately.
- Some professionals may not fully understand the underlying risks of HSB and think it is not serious enough to report or investigate.
- Some professionals may not understand the reasons why children display HSB, seeing them as predators rather than vulnerable young people.

¹ <https://www.nspcc.org.uk/globalassets/documents/publications/harmful-sexual-behaviour-framework-audit-tool.pdf>

² <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/harmful-sexual-behaviour/>

7.2 Recommendations

The following recommendations should be read in conjunction with the HSB Serious Case Review (NSPCC 2017):-

- Specific HSB awareness training to be available as part of the PSCB multi-agency programme.
- HSB training to be part of the AYSE³ newly qualified social workers programme.
- Development of shared understanding of what constitutes HSB and threshold for intervention
- Development of a clear pathway for intervention considering lower level of HSB
- HSB should have a lead officer within the Local Authority to quality assure and support social worker teams with respect to HSB and child sexual exploitation cases in order to ensure consistency of approach and good practice.
- A single assessment should evidence relevant tools that were employed during the assessment, e.g. Brook Traffic Light Tool⁴.
- Consultation with NSPCC or other relevant agencies should be sought as part of a single assessment.
- NSPCC to act as an advice contact for agencies who have concerns about children and young people who display HSB.

Whom	Review
LAPP	08.06.17

Tracey Watkinson
Business Board Manager

³ Assisted Year of Supported Employment

⁴ <https://www.brook.org.uk/our-work/category/sexual-behaviours-traffic-light-tool>