



# West Sussex Safeguarding Children Board

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SCR Response

**April 2014**

## 1. Introduction

- 1.1 This case involves the serious sexual abuse of a number of children by a young person, himself a child at the time. The perpetrator of the abuse is called 'John' throughout this report; this is not his real name.
- 1.2 The serious case review sub-group of the West Sussex Safeguarding Children Board (WSSCB) recommended that a serious case review be initiated in May 2013, when following a police investigation in 2012/ 2013 John had been charged with 55 sexual offences. Whilst some of the victims were not known to agencies in West Sussex, at the time of his arrest there was knowledge locally of allegations concerning six of the victims.
- 1.3 The WSSCB independent chair, Jimmy Doyle, decided to initiate a serious case review in July 2013, on the basis that the criteria were met i.e. that children had been 'seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together'.<sup>1</sup>
- 1.4 The case was additionally perceived to provide learning opportunities more generally about the way that agencies respond to allegations of sexual abuse made by a child against another child ('child on child'); this has not been the subject locally (or as far as is known nationally) to such a learning exercise and the WSSCB wishes to improve multi-agency interventions in this field.
- 1.5 Statutory guidance<sup>2</sup> requires SCRs to be conducted in such a way which:
  - recognises the complex circumstances in which professionals work together to safeguard children;
  - seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
  - seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
  - is transparent about the way data is collected and analysed; and
  - makes use of relevant research and case evidence to inform the findings
- 1.6 In order to comply with these requirements West Sussex SCB has used the SCIE Learning Together systems model<sup>3</sup>. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families and make it more or less likely that the quality of practice will be good or poor. Redesigning the system to make it easier for professionals to safeguard well.
- 1.7 West Sussex Safeguarding Children Board met in February 2014 when it fully accepted the seven findings outlined in Chapter 5 of the Report. The Report was formally signed off on 1 April 2014 once family consultation had been completed.

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<sup>1</sup> *Working Together to Safeguard Children 2013*

<sup>2</sup> *Working Together to Safeguard Children, 2013 Chapter 4*

<sup>3</sup> *Learning Together, Fish, Munro & Bairstow SCIE 2008*

- 1.8 The Board has implemented an action plan based on the findings which include actions already taken to date as a result of learning and other actions required to address the learning by all agencies.

## **Findings**

### **2. Finding 1**

2.1 *Practitioners and managers involved in this case did not have knowledge and understanding of the particular procedure relating to children who abuse other children within the Sussex Child Protection Procedures. If this is reflected in current practice within the wider workforce, there is a risk of responses based on the general child protection process without taking into account specific aspects suited to the particular.*

### **2.2 WSSCB View:**

2.21 The WSSCB acknowledges that there were two volumes of procedures. These were disbanded in May 2011, when the procedures went electronic and are now in one place and run concurrently. These are now updated bi-annually to reflect new guidance and practice.

2.22 The WSSCB is in the process of ensuring that all agencies train their staff in all areas of the procedures and this will be monitored through supervision and an audit.

### **2.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

2.31 Develop a communication strategy which seeks to ensure that all child protection staff are made aware of the relevant sections, and ensure that this is continually refreshed so as to remind staff and to reach new staff

2.32 Arrange an initial and on-going series of multi-agency learning and development days where learning from SCRs is shared and discussed. The first of such days to focus on developing managers' knowledge and use of special circumstances.

2.33 Build the use of 'specific circumstances' in the audit process of Child Protection Teams

2.34 All agencies to provide annual refresher training re the CP procedures. For this to be embedded in the Induction Process for all new staff and in all training. To be monitored through training records and reporting to Board on an annual basis

2.35 E-mail updates to be sent from Tri-X to all agencies and disseminated through line management structures. To be monitored through supervision records

2.36 To review and revise all local agency guidance/instructions/policies against Pan Sx CP Procedures. An on-going robust update to the procedures process which ensures an update to Pan Sx Procedures triggers a review of guidance/instructions/policies and that new guidance/instructions/policies and

changes to such are always checked against Pan Sx procedures. To be monitored through reporting to the Board on a bi-annual basis.

### **3. Finding 2**

3.1 *Joint working between police and children's social care in West Sussex is less child focused and less effective when CID or uniformed officers respond in place of the police child protection team*

#### **3.2 WSSCB view:**

3.21 The Board recognises that achieving best evidence from children, who have made allegations of abuse, and providing further holistic support to them, requires a specialist skill mix of trained police officers and child protection social workers. The Board recognises that when a response to an incident is made by police officers other than the Child Protection Team, this skill mix is not brought to bear. This means that best evidence may not be achieved, and opportunities may be missed to assess wider child welfare issues.

#### **3.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

3.31 Developing an effective Multi-Agency Safeguarding Hub to address this and ensure child is centre to activity

3.32 Develop Safeguarding and Investigation Teams which will effectively bring all investigations relating to the sexual abuse of children into the CPT arena

3.33 Review training delivery in relation to officers who don't work within CPT to ensure that a basic knowledge of procedures is developed

3.34 As part of the Communication Strategy in Finding 1 above, include the need for more immediate and effective communication between officers working in other investigative teams, and officers from CPT, where there is child involvement.

3.35 As part of the audit process in Finding 1 above, ensure that the new 'SCARF' (single combined assessment of risk form) Risk Assessment form is being used where children come to notice.

3.36 As part of the audit process in Finding 1 above, audit the ABE process where children are interviewed by departments other than CPT in order to establish the prevalence of joint working both in planning and conducting ABE interviews by officers other than CPT.

3.37 For Children's Social Care to review the Out of Hours Service and consider how to strengthen the service to facilitate joint working on existing urgent cases.

#### **4. Finding 3**

4.1 *There is insufficient understanding in investigation and assessment that involves Children's Social Care and Police to the exclusion of other agencies, leading to a lack of full information to assist the process.*

#### **4.2 WSSCB View:**

4.21 The Board recognises that working effectively with young people in the context of disclosures and allegations requires forming as full a picture of their circumstances as possible, through processes such as strategy meetings, s.47 enquiries and assessments. Some of the information needed to be put together will be held by a range of agencies, both universal and specialist. It is vital that this information is gathered as part of the processing of determining risks and assessing needs.

4.22 The Board recognises that Sussex Child Protection and Safeguarding Children Procedures clearly state that involvement of professionals other than police and social care should always be considered when holding strategy discussions and meetings. Additionally, information should be obtained from other agencies when undertaking Initial and Core Assessments [and now Single Assessments<sup>4</sup>].

#### **4.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

4.31 Developing an effective Multi-Agency Safeguarding Hub to address this and ensure child is centre to activity

4.32 Revision of WSSCB audit tool to ensure accurate reflection of multi-agency involvement in assessment and intervention in CP cases

4.33 Audit of Early Help cases and CiN cases to ensure accurate reflection of multi-agency involvement in assessment and intervention. Learning from audits identifies and lead to practice changes

4.34 Review and revise Strategy and Meeting practice Standards, guidance processes relating to child on child abuse to ensure effective multi-agency involvement in assessment and intervention

#### **5. Finding 4**

5.1 *There is less clarity in West Sussex about professional child protection roles and responsibilities when the threat to children's safety is external to the family and from an alleged child perpetrator. This impacts on the quality of support offered to victims and their families and on a lack of strategy to address wider issues of public protection.*

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<sup>4</sup> Single Assessment process replaced initial and core assessments in November 2013

## **5.2 WSSCB View:**

- 5.21 The Board recognises the fact that in this case all agencies showed limited or no knowledge of a very relevant chapter in the Pan Sussex Procedures and the agency roles within these circumstances.
- 5.22 The Board accepts that practitioners are unclear about their roles and responsibilities in circumstances when serious sexual allegations are made about a child, but there is not sufficient evidence collected to progress to a prosecution and the child her/himself denies the allegations. Without clarity professionals feel helpless and their responses are muddled and subject to delay.

## **5.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

- 5.31 As part of the multi-agency learning and development days, focus on ensuring staff are aware of how to manage perpetrators and how to properly follow procedures which will ensure clarity in who is responsible for developing strategy in relation to public protection
- 5.32 CSC with Police to develop joint protocol and procedures which set out responsibilities and practice on public protection in child on child cases.
- 5.33 Staff refresher training in information sharing protocols. Information sharing to be embedded in the Induction process and all safeguarding children training. It should be made clear the expectation of monitoring of training records and the expectation of exception reporting and escalation to Board of failure. Auditing of how this has been embedded in practice and what has changed.
- 5.34 To ensure understanding to staff through written and verbal briefings to staff to publicise service for post pubertal children

## **6. Finding 5**

- 6.1 *Complex database arrangements within CSC and police, and the reliance on individuals to insert and maintain linkages, prevent quick and accurate identification of all relevant history in circumstances when there are a large number of victims involved*

## **6.2 WSSCB View:**

- 6.21 The Board recognises that the proliferation and design of electronic databases did not support workers to 'make links' between the different children involved. This led to an overreliance on individual workers to remember the links between individuals, which is unreliable and unsustainable in the long term, and means that patterns of offending and behaviour were not detected.

### **6.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

- 6.31 Sussex Police now have an electronic system (Niche) in place capable of addressing the issues highlighted in both this report and in the two previous serious case reviews mentioned.
- 6.32 Sussex Police to devise an audit to assess the impact of Niche as an aide to research.
- 6.33 Sussex Police will explore the use of e-CINS as a means of developing a joint agency application for sharing information in relation to child protection
- 6.34 Frameworki prompt to link known/suspected victims/abusers at point of addition to system and when subsequent information is received
- 6.35 As with Findings 1 and 3, the development of an effective Multi-Agency Safeguarding Hub will be given due consideration as the key to addressing this issue

## **7. Finding 6**

*7.1 There is a lack of effective assessment and intervention tools in West Sussex for children who are abusers, but deny allegations and are not able to be prosecuted.*

### **7.2 WSSCB view**

- 7.21 The Board recognises that the needs of young people who sexually abuse are complex. There is growing awareness and acknowledgement of the incidence of sexually harmful behaviour by children and young people. Although the establishment of a National Youth Justice Board provided an opportunity to address the development of services for young people who sexually harm in a more strategic and consistent manner, there still appears local and national concerns about a lack of a coordinated response. The issues are compounded and wider public protection issues increase, when the young person fails to engage. In addressing the lack of opportunities due exploration will consider the expertise of national agencies i.e. Research in Practice and national voluntary organisations.
- 7.22 The service in West Sussex has in recent times worked hard to engage young people who are initially reluctant to attend and to provide consultation to the professional network, but this has not been robust.

### **7.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

- 7.31 An exploration of national tools via recognized and accredited organisations that are available and for these to be disseminated to the workforce

- 7.32 An Evaluation of ATS in terms of the finding in relation to abusers who deny allegations, how it can best work with and inform other agencies in terms of risk management
- 7.33 The Board will direct all agencies to have briefing sessions on Assessment and Treatment Service (ATS) and Assessment and Intervention Moving On (AIM) as to what is available.
- 7.34 CAMHS will strengthen the capacity of specialist AIM assessors within ATS who would undertake this work on a regular basis. A report will then be fed back to the Board as to progress.
- 7.35 To identify best practice and revise practice standards and process for multi-agency reviews of young people who pose a risk to other young people and children
- 7.36 To develop a multi-agency procedure re AIM

## **8 Finding 7**

8.1 *The Child & Adolescent Mental Health Service (CAMHS) current systems do not focus sufficiently on the need for proactive follow-up for those young people identified as vulnerable, who do not attend subsequent appointments.*

### **8.2 WSSCB view**

- 8.21 The Board acknowledges that the issues with which young people present to CAMHS may have safeguarding implications, either for their own safety or for others.
- 8.22 The Board recognises that this case has suggested that:
- There is a lack of guidance around the need (or not) to make contact with children's social care for information prior to the initial Choice appointment of vulnerable young people;
  - There are no consistent systems for following up young people about whom there are safeguarding concerns (e.g. suicide, substance misuse, aggression, accusations of sexual harassment) and who choose not to engage, including guidance when to involve children's social care

### **8.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

- 8.31 For CAMHS commissioners to review CAPA approach in the current re-commissioning of the service and inform the Board of their findings
- 8.32 For CAMHS to develop, implement and monitor an effective system to follow up 'was not brought' cases. Monitor through audits and report to the Board

- 8.33 To ensure that selected senior administrators within CAMHS have access to Frameworki to enable whether young people referred to CAMHS are also known to CSC. Then following the Choice appointment and after discussion with the family, a decision can then be made regarding the need to liaise with CSC.