City of York
Safeguarding Children Partnership

7 POINT BRIEFING:
Child P - Learning from Practice

1. Child P is an only child who lived with his Mother and extended family. Both parents were described as having some level of learning difficulty. Maternal grandmother was supportive and a positive influence to Child P. It was during the critical period in the case that the grandmother died. Child P has a learning disability and ADHD and attended a school for children with special needs. From age 11, Child P received support from children social care disability services and CAMHS.

2. Between 13 and 15 years, Child P was subject to a Child Protection Plan (CPP) which was instigated due to the risk of sexual harm from a maternal uncle. Child P never disclosed any instances of sexual abuse but was known to be accessing pornography. The plan continued due to concern that parental care was ineffective in addressing his needs, including the risks associated with harmful sexual behaviour (HSB). At age 14-15, there were 6 incidents over 12 months of sexualized/sexually harmful behaviour which occurred whilst subject to a CPP.

3. One month after the CPP ended, Child P was discussed at the Forensic Panel. A plan of work was recommended and medication introduced which it was believed would reduce impulsive behaviour. The panel set no date for review. Three months later, two further incidents of sexual behaviour occurred which were not reviewed in the context of ongoing HSB. Aged 17, Child P committed a serious sexual offence against a 4 year old child.

4. Strengths of multi-agency working:

- Proactive and inclusive approach to working with a child with a Learning Disability.
- Good knowledge of the family dynamics and how they impacted upon Child P.
- Timeliness and agency commitment to multi-agency child protection processes.
- School commitment to managing risk and maintaining education.
- Acknowledged that parents required additional support by virtue of their capacity to engage.
- Child P supported to achieve an alternative to custody that would meet his needs and provide a conducive environment for challenge and progress to change.

5. Limitations:

- Insufficient focus on risk assessment of HSB within the CPP and the assessment lacked multi-agency responsibility and review.
- The safety plan was unrealistic in managing the risk of HSB in the family and community.
- Lack of multi agency confidence in escalation processes.
- An absence of specialist information available to practitioners managing HSB. Lack of combined knowledge in practitioners working with HSB and learning disabilities.

6. Learning Points:

- All situations where HSB is alleged should be referred to Children's Social Care.
- Harmful sexual behaviour places complex demands on multi-agency professionals. Access to specialist support/casework advice through nominated champions would increase confidence and contribute to better outcomes.
- Within all children's plans, when a child presents a risk of HSB, this should be explicitly articulated and all potential areas of risk identified to both the subject child and any potential victim children. An interim safety plan should be in place when specialist or other assessment is awaited. The safety plan should be reviewed at each multi-agency meeting and additionally in line with any changing risk factor.
- Children's Social Care should give consideration to strengthening the oversight of Child in Need Plans where children are open to the Health and Disability Team.
- Allegations of HSB should be considered under child protection procedures for both the alleged victim and alleged perpetrator. The needs of alleged victim and alleged perpetrator children should be considered separately and in accordance with child protection procedures.
- For children with additional complexities and communication challenges, the partnership requires access to specifically skilled practitioners to undertake direct work and skilled investigative interviews.

7. What next

- The learning from this case will be shared across the City of York Children's Safeguarding Partnership (CYSCP).
- CYSCP will commission multi-agency training in HSB with a focus on children with learning difficulties and disabilities.
- Assurance from partners sought that relevant professionals access the training consistent with their level of responsibilities e.g. professionals working with children with learning disabilities require specialist training in this area.
- A multi agency strategy and guidance will be developed to include specific reference to children with a disability and will be informed by the NSPCC and CYSCP audit of HSB.
- Across the multi-agency partnership awareness raising will be undertaken of the role and responsibilities of the Forensic Panel.
- The Youth Justice Service will scope and share with the partnership what is currently available and what is required across the partnership for the assessment and development of interventions for children with LD, additional complexities and communication challenges with regard to HSB.

Where do I go for further information?

Please visit the CYSCP website for up to date information and latest news.

Please also sign up to the CYSCP Newsletter and follow us on Twitter @YorkSCP