Tameside Safeguarding Children Partnership

Local Child Safeguarding Practice Review - Craig

1. Introduction

1.1 Child Safeguarding Practice Reviews, formerly Serious Case Reviews (SCRs) in England are undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected. Additionally, Local Safeguarding Children's Partnerships (formerly LSCBs) may decide to conduct a local safeguarding practice review if a child has been seriously harmed and in accordance with the guidance in Working Together guidance (2018).

1.2 The Panel and local partners help to identify serious child safeguarding cases that may raise issues of national importance. They commission a review that involves all practitioners who may be relevant or have information that will help to provide learning for future practice.

1.3 Tameside Safeguarding Children Partnership (TSCP) considered the case of Craig in December 2019, the case being referred by Greater Manchester Police (GMP) and agreed that the case should be conducted through the local child practice review. The Practice Review Group considered that there was significant concern about the circumstances of Craig's allegation of rape by another child living at the children's home, to merit scrutiny and learning. Agencies were asked to develop a chronology of significant events for child Craig and Z. In March 2020, the Government issued restrictions termed 'lockdown' due to the developing pandemic conditions from Coronavirus, and agencies were no longer able to meet face to face to continue to work on this case. Agreement was reached that work would continue via digital means and there would be no meetings with practitioners and managers due to the restrictive conditions. This review, therefore, has not had the benefit of practitioner engagement by way of a learning event, and limited by the engagement of nominated officers for this review. Nevertheless, the learning has been developed for this review and the key agencies have contributed with adapted methodology. The review group considered different methodologies that could be used for the analysis and learning for this review and Tameside Safeguarding Children Partnership had recently developed some limited learning from a neighbouring Safeguarding Partnership. However, the experience was not as extensive as was felt necessary to oversee the review and agreement was reached about using the experience and skill within the practice review group lead by the interim Head of Safeguarding who had not previously worked within the authority which ensured a level of independence. The focus of the review was agreed as follows:

- To consider the contractual arrangements for private providers within Tameside and placing authorities with regard to their safeguarding requirements and whether they meet with Ofsted standards. Specifically, this should cover individual risk assessments of placed children.
- GMP recording and management of crimes and allegations of peer-on-peer abuse.
- The involvement of all partners in Strategy Meetings by the children's social care.
- Children's social care recording and progressing notifications and section 47 investigations (enquiries under the Children Act (1989).
- There is further learning for London Authority 1 regarding Z: the risks he posed on placement and the appropriateness of his placement. (London Authority 1 are aware that they will need to identify their own learning in relation to Z).
- Reporting of incidents to GMP by other agencies, when they occur, to determine whether a crime should be recorded.
- Record keeping for all agencies to be examined against best practice guidance in safeguarding and any gaps identified. Agencies to address record keeping and to document rationale for decisions made.

The learning summary was agreed to be produced to support the key questions and learning for each child, Craig and Z, and actions that would arise from this.

2. Methodology

2.1 Tameside Safeguarding Children Partnership had been using a number of methods to develop the partnership approach to learning from cases and had more recently initiated some learning with Salford Safeguarding Children Board. Some limited training had been undertaken with members of the partnership, including members of children's service middle management. For this review a member of

the local authority's Safeguarding Unit, a Performance Improvement Manager, facilitated the production of the chronology for the department. The overview author is a Head of Safeguarding (interim) who has several years' experience in safeguarding practice and management and has not worked in the authority prior to this review began. The reviewer was part of the Social Care Institute of Excellence (SCIE) in 2010 to pilot a new systems methodology for serious case reviews.

2.2 Due to the pandemic conditions, there were restrictions on how the review would be conducted and agencies had stepped down face to face contact this meant that meetings such as learning events with practitioners, a cornerstone to the development and learning, could not be facilitated. It was therefore agreed that the following would be produced:

- individual agency chronology of significant events from 2016-2019
- an individual agency learning summary based on key questions relevant for this review
- the author would produce an overview report based on the actions and learning for each agency and for the partnership
- a final report would be produced for the TSCP Executive for recommendations and actions

2.3 The dates were agreed by the practice review group as the significant event period from when Craig was placed in residential care (2017) to (2019) when he was sexually assaulted with a key focus on safeguarding practice during this period. For Z, London Authority 1 was asked to review from 2016 when Z was placed in the Children's Home to his placement ending in February 2020.

Agencies involved in this review were:

- Tameside Children's Services: looked after children, independent reviewing officer and special education teams
- Provider 1 - provider of care and education at the Children's Home and attached School
- Health- Designated Nurse Tameside & Glossop CCG on behalf of primary care looked after children Health Services and mental health services.
- Stockport children's service
- Greater Manchester Police (GMP)
- London Authority 1 Children's Services for child Z

2.4 Involvement with Craig and his family- Craig's father met with the reviewer, through digital means, and he was updated on the review process and he gave his views on the events that led to this review. He was aware that there was an outstanding criminal charge with the Crown Prosecution Service over the allegation from Craig. The reviewer saw Craig in his new placement in November 2020. This was with a view to gaining Craig's view of the circumstances of his placement and how the allegation that led to the criminal investigation had been managed and how he was therefore supported. Craig disclosed to his residential staff members, on that day, that he had been sexually abused over a year by Z and that Z had told him he had also sexually abused another child. This information was recorded and passed to GMP for consideration. GMP had decided that Craig would need to be interviewed again. At the time of this review being finalised criminal proceedings have been completed and Child Z is serving a custodial sentence.

Given the significant time span it has taken for this review to be completed a further author was identified to complete the review after the previous reviewer had left the organisation. The second author has shared a full copy of the review with Craig's mother and father and met with them to discuss findings. They have made telephone contact with the author and although they remain extremely upset by the abuse of Craig they are happy for the review to be published.

3. Craig's early childhood

3.1 Craig's family has been known to another neighbouring authority and Tameside Children's Services on a number of occasions since 2008. The family became known in 2010 due to concerns about the welfare of Craig and reports of parental drug use over lengthy period. Craig was supported in early life by his paternal grandmother and lived with his paternal grandmother on occasions in his early years.

3.2 Craig experienced an unstable, transient, and neglectful care in his early years. Significant concerns were raised in relation to the care Craig received with regard to supervision, home conditions, stimulation and having his basic needs met. The events that culminated in Tameside Children's Services issuing care proceedings in 2012. Craig was returned to his grandmother and father's care. Initial

arrangements were that Craig would remain with his father and paternal grandmother and contact with mother should be supervised. Father and paternal grandmother struggled to manage.

3.3 Craig's father was sent to prison and there was no other responsible adult to care for him. Proceeding this period of time, Craig was subject to a child protection plan. Craig was made subject to a Care Order in October 2013 to Tameside Children's Service, and his care plan at the end of care proceedings was for him to remain in foster care and long- term carers to be identified for him.

3.4 In the period between October 2012 and March 2015, Craig experienced further instability in terms of foster placements of various compositions. A number of breakdowns occurred. Craig's father was assessed positively after a period of engagement and interventions. He consistently sought to return his son to his care. A decision was made for Craig to be returned to his care under a care order already in place making him subject to a placement with his parent (Care Planning, Placement and Case Review Regulations (2010). Craig received a diagnosis of ADHD & Conduct Disorder in Aug 2016. Craig's father struggled to cope with meeting Craig's needs and deteriorating behaviour. Several safeguarding concerns were raised during the period between March 2015 and October 2016 whilst Craig resided with his father subject to a care order whilst placed at home.

3.5 Craig was then placed in a foster placement. Unfortunately, this placement ended at time when his Education Health Care Plan was underway and also medication for his diagnosed ADHD. Craig was placed at the Children's Home, in Stockport, in an emergency in August 2017. Craig was then aged 9 years old. Exploration of alternate foster carers was unproductive and the decision to seek a therapeutic residential placement for Craig was agreed.

4. Placement at the Children's Home including matching process.

4.1 Tameside Children's Services considered that other alternatives had been explored for Craig, and that whilst a residential placement was not ideal for such a young child, (aged 9 years), there had been no other suitable alternatives for him. He was placed in an emergency placement as his previous placement had broken down. The referral was made in August 2017 and he moved the following day. There was no visit to Craig prior to placement from the residential carers as the placing social worker did not think he would manage it given the immediacy of the placement needs. The social worker did not visit the placement as it was an accelerated move due to Craig being placed in temporary foster placement for one week and the placement ended on the day after the referral was made. The manager from the home sent the children's guide and information about the home to the foster carer and had spoken via email to the carer with regards to Craig's needs. The residential unit notes that at the time no reference in the referral documentation by the social worker or the independent reviewing officer (IRO) to reports of Craig having 'no history of making false allegations'. This issue is explored later.

4.2. The initial referral documentation provided to the Children's Home reported that Craig had experienced: a chaotic lifestyle; had witnessed family issues relating to drugs and alcohol; had been exposed to domestic abuse/violence; lack of boundaries. The referral rationale for residential placement of a boy aged 9 years old at the time is summarised as Craig 'is a complex young man and my view is that we need a residential therapeutic placement which can meet his needs long term. I would argue that residential staff can work together as a team and take breaks where necessary as opposed to foster placement which is more intense.' The referral documentation gives a detailed account of Craig's needs in relation to his health, education and emotional needs.

4.3 When Craig was placed by duty social workers from Tameside's support team, the Children's Home record that the physical placing of Craig, by the duty workers, was brief as it is usual practice for this to be a more planned arrangement with time to settle the child into the placement. The Tameside social worker's case recordings in relation to his placement, and settling at the residential unit, are brief also. Appropriate placing documentation was provided to the Children's Home to include Delegated Authority and a Placement Plan as well as details in relation to contact arrangements for Craig with family. Initial planning indicated a short- term placement for Craig at the Children's Home, however as time progressed, and without formal planning from all agencies, this placement became longer term even although the agreed outcome of long -term fostering remained. Craig's care plan became one where he would be at the Children's Home until a period of time where he would receive therapy and that rehabilitation back to any family member would not be appropriate and long- term fostering was to be the longer-term plan. Contact was agreed with both parents, but this was not regular as both parents found this difficult to keep to. The placement provided educational provision through an attached school and his EHCP was transferred to the local area. The placement is recorded in his looked after

reviews as being positive for him with a consistent staff unit and children. There were 4 children, all boys, in the care home which was felt to meet his needs. The home had received 'good' Ofsted ratings in the preceding years and those professionals that formed part of the care planning arrangements considered that it was as suitable placement for Craig having had several years in placements that had disrupted.

4.4. As part of Craig's placement at the Children's Home Craig had an initial psychological assessment undertaken as part of a psychologically informed process which is undertaken on all children placed with Provider 1 and agreed at referral stage. The pathway involves; gathering relevant background information about each young person, completing a methodical psychological assessment, including assessing their cognitive ability, mental health and feelings, gathering information from the care team about the young people's life skills, mental health, behaviour and functioning and completing a checklist about the child's current functioning, using a clinical evaluation tool which includes risks, behaviour, well-being and relationships. The formulation meeting held at the conclusion of the assessment gave the team a framework for care. He had experienced five significant life events in the preceding six months. These included: a change of placement, school, carers, change of another child in placement (arriving or leaving) and a change in contact arrangements. He had also had a number of social workers prior to the current social worker. His attendance and behaviour at school improved although there were still concerns about his aggressive outburst which continued to present in his behaviour. The records report that he settled in and he was referred to the Healthy Young Minds service in Stockport for continuation of his attention deficit hyperactivity disorder medication reviews. Notifications to health partners were not timely. The looked after children health team, who were responsible for ensuring health elements of the care plan are up to date, were notified 3 months following the placement. There was little information shared with health partners regarding past social history and exposure to adverse childhood events as the health information was not transferred to the relevant host authority by the local authority. Thereafter, an annual health review and assessment took place and noted at the statutory care plan review. Therapeutic interventions, provided by the residential home, were not shared in detail at the statutory reviews. This was in isolation to other assessments and aspects of the care plan as there was no evidence that information was shared between professionals/agencies with regards EHCP, therapeutic interventions, and ADHD.

Key analysis and recommendations on the placement:

4.5 In terms of Craig being matched to a potential placement at the Children's Home, the commissioning team at the time brokered the placement, which was then pursued by the social work team, in the absence of the allocated social worker. The social work team accepted the available placement after consultation with the residential unit manager at the Children's Home. Tameside social care files do not record any details in relation to the matching process conducted between the duty social worker's/team manager and the residential unit. The placement was in reasonable distance from Craig's home and they accepted Craig and the placement was agreed. Social Care files do not reference any discussions in relation to matching/risks with other children in the residential home. The Children's Home residential unit manager recalls a general discussion about the other children but not specific that Z was discussed and was not able to verify in the records that this occurred either with duty workers or the allocated social worker, whose initial visit to the home was 5 days' post placement.

4.6 There was an impact assessment completed as part of the admissions process by the Provider, but this was not shared with the Craig's social worker. The Children's Home chronology record that whilst it was completed 'however did not record the risks from others and namely the potential for sexually inappropriate behaviour from Z'**.** The allocated social worker states they were not made aware of any risks in relation to other children in placement and noted that the unit was well staffed. There had been two allegations involving Z, one where he locked himself in the bathroom with a 7-year-old child and another when he went into another child's room (aged 9 years) and asked him to go into his room. The impact risk assessment provided for this review by the Children's Home for Craig was completed after admission in 2017. It does not identify any risk from other children or from Craig but notes there could be 'violence and aggression'. There is no standard question asking about 'false allegations' but it is noted by the Children's Home. Provider 1 senior managers consider this may have been influenced by the social workers view that Craig was not always truthful about events in his life and often 'fantasized' about life events and discussion in analysis section below.

4.7 Analysis: In terms of commissioning of residential placements, at Tameside in 2017, there was limited processes in place other than the initial brokerage of the placement. Current commissioning

arrangements at Tameside have been updated after a period of investment with a number of processes and procedures now in place to ensure quality assurance of commissioned placements. The reviewer was provided with updated drafts of the new processes and the safeguarding aspect of this process of ensuring that risk assessments and impact assessments by the Provider, prior to admission, are to be included within this. Some of the changes within the commissioning framework are:

- Initial visit to home by social worker
- Discussions between home and social worker about appropriateness of placement and match-after commissioning have brokered possible placement (could be telephone call in an emergency)
- Initial visit to any new home by Commissioning either before placement if planned or within 72 hours if new placement to Tameside
- Commissioning records/checks for home in relation to OFSTED, Regulation 44 visits and Statement of Purpose
- Commissioning on-going monitoring/recording of monthly Regulation 44 visits and OFSTED reports
- Placement Tracking panel regarding on-going placements –review dates of placements on a regular basis

4.8 Provider 1 have informed the review that they have updated their risk assessment processes, further to a review in 2018, with a number of new processes and procedures now in place to ensure improvement in risk assessment and the communication of information about risk during the referral and admission process:

- The Referral, Admission and Discharge Policy was reviewed and revised in June 2018 to include a requirement on each home to drive pre-admission visits, information sharing and gathering.
- An enhanced and improved Provider 1 Referral Form has been developed, to be completed by referring social workers.
- An improved Impact Risk Assessment Template has been developed and implemented (provided to this review).
- There will be an additional pre-admission internal meeting of all relevant parties within Provider 1 to review the needs and risks of a child coming into a service and the creation of an action plan to support good risk management.
- An internal checklist is completed on an internal software system and escalated to internal National Specialist Advisors who can support the home to ensure robust risk management arrangements are in place and to liaise effectively with other agencies.

4.9 Provider 1 report that there are now systems and support in place to allow home managers to escalate concerns to other agencies including challenging and advocating for the needs of children. With regard to the statement about Craig making 'false allegations' the reviewer considers that this is not an appropriate question, to be asked or made, unless there was undisputed evidence that it were to be true. It is likely that this remark was influenced by the placing social worker stating that Craig 'fantasised' about life events as confirmed by his previous foster care agency who noted that he had a 'history of making allegations against previous carers'. The foster care agency document noted 'Carers should familiarise themselves with all aspects of safer caring policy and implement control measures as far as possible to reduce risk of allegations'. However, it is wrong to conflate that with a finding of false allegations and it had influenced the view of Craig, who was a vulnerable child, and needed his allegations to be taken without a pre-conceived view.

Recommendation: 1) Tameside Children's Services should review their procedures/practice standards in relation to the placing of children in emergency placements. This should include reviewing the commissioning process being developed to ensure that impact risk assessments are being conducted and shared appropriately with placing authorities.

Recommendation 2) Provider 1 should further develop their impact assessment to ensure that it identifies the children who have harmful behaviour and a risk to other children with clear mitigations in place. This should include how this is shared with other placing authorities, including in writing.

4.10 At the time of Craig's placement, the Children's Home were aware of sexually harmful behaviour with Z in relation to an allegation made on 2017 where Z locked himself in bathroom with 7-year-old resident A. Z denied that he asked him to undertake a sexually abusive act and claimed it was the younger child who had asked Z to do this. The chronology outlines that the placing social worker (for child A) were informed of this concern and 1:1 staffing was put in place, and whilst the allegation was retracted by the younger child, consideration should have been given to the age difference between the two children to inform whether the allegation was likely to have happened on the balance of probability. Also, the placing authority had detailed concerning sexual behaviour of Z with a sibling (prior to placement) necessitating therapeutic input at the Children's Home. Notably the allegation in 2017 was not reported to GMP at the time but was reported to the placing social workers. It was recorded as an allegation retrospectively by Z's placing authority in January 2019 to GMP, collectively with a number of other allegations during the investigation of December 2018. This allegation was referenced in Z's Assessment, Intervention and Management (AIM2) assessment completed in May 2019 along with other allegations made against Z.

5. Findings on the post placement period

5.1 Craig was placed in an emergency due to placement breakdown by duty workers and his first statutory visit was conducted by his allocated social worker 5 days post placement. In terms of the physical placing of Craig at the Children's Home good case management would have paid consideration to Craig's numerous risk factors associated with placement to include: placed in an emergency with no prior visits or introductions; Craig aged only 9 years old and being placed in a residential setting for the first time, Craig's allocated social worker being on annual leave until the following week, Craig being placed out of borough although not at a distance, Craig having moderate learning difficulties, Craig being administered medication for ADHD by the home. In such circumstances greater efforts to ensure Craig settled and a lengthier social worker engagement with Craig, and the staff at placement, would have been beneficial for Craig.

5.2 Craig was under the care of Tameside HYM on the treatment pathway for ADHD who provided regular medication and treatment reviews. There appears to be a lapse in care following the fostering placement breakdown with the last entry from Tameside HYM in Jan 2017 until a referral by to HYM Stockport in October 2017 for medication review. ADHD reviews were often undertaken in isolation to wider needs such as education information and therapeutic interventions. There is no record that HYM were made aware of any allegations made by Craig.

5.3 Statutory guidance states that, as a minimum requirement, an initial visit by the social worker should be conducted within one week of placement, and then weekly until first statutory care review takes place outlined in the Children Act (1989) guidance and regulations Volume 2: care planning, placement and case review. Good case management would have paid consideration to Craig's numerous risk factors associated with placement to include: Craig being placed in an emergency with no prior visits or introductions, having experienced numerous placement breakdowns, not seeing the social worker for five days, who found him to be quiet and subdued at the first statutory visit at placement. In such of circumstances, whilst guidance states that the first visit should be within 7 days, good practice and consideration of other risk factors would suggest much sooner. The following day would have been more advisable. Craig's Placement plan indicated that Craig's Social worker would visit on her return to work. It described Craig as 'a child who needs to be fully supervised at all times, partly due to his anxiousness when left alone but also due to his age and behavioural issues'. Where children are in receipt of specialist services the placing local authority should have a clear plan to ensure continuity of care and specialist services/clinicians consulted when children are placed in an emergency. Partner agencies should be made aware of changes to circumstances within 5 days by the local authority if they have not been involved in the placement and care planning for this move. Ideally this should be via telephone if outstanding needs or specialist services are involved.

> **Recommendations 3)** Provider 1 should ensure that they seek clarification from the placing authority with regards to the arrangements for holding the 72-hour placement review so that the correct information is gathered, and the child's needs are assessed appropriately.
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> **Recommendation 4)** Tameside children's services should ensure there is a system in place for informing partner agencies when children are placed in emergency within 5 days by the placing

social worker. This must involve notification processes to other agencies involved. This should be via telephone if outstanding needs or specialist services are involved.

6. Response to emerging risk at the Children's Home: incidents/allegations

6.1 The Children's Home report that the initial referral documentation detailed Craig had a chaotic lifestyle, had witnessed family issues relating to drugs and alcohol, domestic abuse and lack of boundaries. He had eleven placements in two years, and this was his first placement in a residential setting. With regards to Craig's education, it was reported that academic achievements had been low, and he required a specialist facility. Craig had an EHCP plan to support him, but it was not widely available to key professionals involved. His presentation at the time of referral was described in the Children's Home's learning summary to be of 'violence and aggression'. Craig was generally healthy and was prescribed medication for ADHD and to aid his sleeping pattern which was disrupted. The social worker during her visit 5 days post-placement, and the foster agency care plan, had suggested to the Children's Home that Craig tended to fantasise and might not be credible. A psychologically informed process report dated November 2017 recorded that 'Craig had a tendency to tell lies and exaggerate the truth quite often' often about his family. This led those who were dealing with Craig to have a view that allegations of abuse were to be treated with a level of disbelief given there was a firm view about his ability to fantasise. This position then affected how he would later be regarded when he made allegations concerning child Z.

6.2 Craig made a historical allegation of sexual abuse by his 'father' in early 2018, which was overheard at school and the social worker reported this to the police. The police learning summary notes that this was referred to them and a joint visit with CSC was set up with Craig to assess the veracity of the allegation.

6.3 Achieving Best Evidence (ABE) in criminal investigations (Ministry of Justice 2011) for vulnerable witnesses in criminal evidence gathering provides guidance in respect of initial contact with victims and witnesses. The need to consider a video-recorded interview will not always be immediately apparent, either to the first police officer who has contact with the witness or to other professionals involved prior to the Police being informed. Even where it is apparent, the need to take immediate action in terms of securing medical attention and making initial decisions about the criminal investigation plan might be such that some initial questioning is necessary.

6.4 Any initial questioning should be intended to elicit a brief account of what is alleged to have taken place; a more detailed account should not be pursued at this stage but should be left until the formal interview (ABE) takes place. Such a brief account should include where and when the alleged incident took place and who was involved or otherwise present. This is because this information is likely to influence decisions made in respect of the following aspects of the criminal investigation plan: Forensic and medical examination of the victim; Scene of crime examination; Interviewing of other witnesses; arrest of alleged offender(s); and Witness Support.

6.5 Craig was asked by the police officer if he was being truthful; he 'shrugged his shoulders'. Craig then denied that anyone had touched his him as per the overheard conversation at school. The allegation did not progress, and the police took no further action (NFA). The Police overview of this incident stated 'note similar in 2016' regarding a foster father where Craig had reported retrospectively that in 2014, he had been sexually assaulted whilst in care. This had been formally investigated by a neighbouring local authority, and the police, where the foster carers were registered. There was a view, documented in the social care learning summary, that as the identity of the alleged offender could not be ascertained, such as between his biological father and his former foster father, the allegation could not be progressed criminally. Both the PPI and Crime had supervision oversight which agreed with this decision.

6.6 It is not clear from the recording from either the Police officer or the social worker what the conclusion of this allegation was. There is no strategy meeting to consider the allegation as outlined in the applicable Working Together (2015) statutory safeguarding guidance. This meant there was no outline plan as outlined in Working Together- 'Local authority social workers are responsible for deciding

what action to take and how to proceed following section 47 enquiries.' Section 47 enquiries refer to the Children Act (1989) which confers a duty on local authorities to investigate and assess a child's welfare. At this stage the status of the allegations was that it was subject to section 47 enquiries and whilst the Police could not confirm whether there was any veracity to the allegation the social worker is still required to consider the concerns raised as 'on the balance of probability'. The role of the social worker appeared pedestrian, suggesting that the criminal burden of proof ('beyond reasonable doubt') is given primacy in joint investigations. This concern was identified by the Children's Commissioner in a report entitled Protecting children from harm (2015). It highlighted the need for 'the role of social workers in the interview process has diminished, leading to concerns that the substantiation of sexual abuse is often delegated to the police using the criminal burden of proof'. There is equally no evidence of management oversight in the decision making from CSC which is a requirement and standard set out in Tameside children's service and therefore no clarity nor hypothesis about the reasons for Craig making the allegation. This is also a requirement in concluding section 47 investigations-this did not happen in this case and there continued to be a belief that he was 'lying' about this and other concerns he raised.

Recommendations

> **Recommendation 5)** TSCP should ensure that GMP and Tameside Children's Services should review the recording and management of section 47 enquiries when children raise allegations of abuse so that they meet Working Together requirements and that there is management oversight and sign off.
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> **Recommendation 6)** Tameside Children's Service should review the role of the social worker in joint investigations so professional expertise is exercised with regard to allegations which are considered to be unsubstantiated and or false.

7. Further safeguarding concerns 2018-analysis and findings

7.1 The next safeguarding reported incident recorded by the Police relates to an incident by a pupil at school who attended the Police station with the Head Teacher to report that Z had approached them at school and asked them for 'oral sex'. The incident was recorded in May 2018 but happened in school in the March 2018. There were no witnesses to this alleged offence and the Police considered it was not in the public interest to progress. The incident was reported to the Police in May 2018 and involved another child from another local authority outside of Greater Manchester.

7.2 Provider 1 report that a strategy meeting had been undertaken but this did not include the Police (no record of such). And the Head teacher at school felt it necessary to make the Police aware albeit this was not until May. Provider 1's summary report that this was a child not in their home but from a home outside of Greater Manchester and the incident was reported to the social worker and to London Authority 1 as it concerned Z. They recorded that there was an 'internal meeting' at school and the Head teacher sought advice from Stockport 'safeguarding' who advised to notify the placing authority for the child who was the alleged victim. The summary reports that Z's risk assessment was updated. Provider 1 also commented the following: 'In May the Head teacher finalised an investigation report which concluded that the allegation was unsubstantiated due to lack of evidence'. The reason given for the retrospective reporting to the Police in May was that the Head teacher considered that the Police ought to know that an allegation had been raised. There are a number of issues from this incident: foremost it is not the responsibility of the Head teacher to conclude a safeguarding investigation between two pupils.

7.3 The investigation of allegations of abuse is a matter for the local authority to investigate through section 47 inquiries with the Police if the threshold is reached for a strategy meeting. The motivation of the Head teacher would likely to have been with good intention but outside of their competence and role. The role of the Head teacher, and other teaching and support school staff, is to recognise and report safeguarding concerns to the statutory investigative agencies namely the local authority children's services and the Police.

> **Recommendation 7** – Provider 1 should ensure that Head teachers and teaching staff are aware of their role and responsibility, in the event, that they have to report and support a statutory safeguarding investigation involving children/pupils within their schools. In particular, Provider 1 must ensure that staff report directly themselves and not assume that other agencies are reporting concerns.

7.4 The next safeguarding incident reported was in June 2018 when Craig reported to the Children's Home staff that Z had been knocking on his door at night and that Z had tried to force him into an abusive act. Craig could not recall what happened next when asked. The Children's Home notified Tameside Emergency duty service. The case note reads that the member of staff from the Children's Home stated, 'that she is aware that Craig tells stories at times but she is taking this seriously'. The following day the social worker spoke to Craig at school, he alleged that about a month ago Z had gone to his room in the middle of the night and tried to coax him into going down to his bedroom. Craig's social worker did not arrange a strategy discussion as there was a view that there was no 'evidence' to support this allegation. Craig's social worker notes: 'continues to not tell the truth and is making allegations and then retracting the information when questioned for further details'. In addition, the Children's Home had considered that Craig's room was right next to the staff room and they would have been aware of this as Z would have had to have passed them.

7.5 The social worker visited the home in early June 2018 and concluded that what Craig was likely to have 'dreamt' these incidents. This was considered to be a retraction by the social worker. There was a review with the Provider 1 therapist in line with the psychologically informed process with the home manager and social worker. Craig was being offered this therapy whilst he was placed in the Children's Home: it covered various aspects of Craig's recent behaviour and achievements such as school and relationships. The therapist considered that Craig tended to 'move into victim role a lot – when he has done something wrong'. The top concern for the staff and the Children's Home was Craig's 'lying' as well as other behaviour problems. It went onto state 'Craig can embellish and exaggerate stories – he will make something up on a daily basis, such as something that happened in school which when checked out did not happen but there may be a grain of truth in his story'. In the *risk* area the only area identified was 'making unfounded disclosures'. The lack of professional curiosity about the allegations being made influenced and shaped how subsequent concerns were dealt with and the social worker and Children's Home staff group appeared not to consider whether there was any veracity to these. A more neutral and enquiring position would have supported further exploration of the allegations.

7.6 Analysis and recommendations- There was by this point a view held staff working with Craig that he was not to be believed. This view was over-relied upon by professionals and does not appear to have been challenged. This did not protect Craig and limited his opportunity to be a witness to criminal sexual assaults that later transpired to be truthful (detailed later). This was underdeveloped practice and should have formed part of the scrutiny by the Independent Reviewing Officer (IRO) and managers, who chair the formal care planning review, and whilst it is understood that these reports were not formally submitted to the review by the social worker, they were loaded onto the child's electronic record and should have been included within the written social work report submission for the review. There was also no sharing of this information with the wider professional group and as there is no clear account of why this was the case it is likely to have been influenced by the lack of weight attached to the credibility of such allegations.

> **Recommendation 8)** Tameside Children's Service Independent Review should ensure that reviews of children looked after must include a full account of any therapeutic input and the how it integrates with the care plan. It must also include any updates on allegations/safeguarding concerns raised. The efficacy of any such therapeutic work should be reviewed by this forum.
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> **Recommendation 9)** Provider 1 must ensure that risk management plans that are put in place by a children's home should be reviewed by the statutory reviewing function and not solely by the children's homes own staff.
>
> **Recommendation 10)** Provider 1 should review the training for their staff with regard to children who disclose abuse: specifically, the role of residential workers.
>
> **Recommendations 11)** Tameside Safeguarding Children's Partnership should review the training for staff that are responsible for conducting investigative interviews with children to ensure that there is sufficient skill and expertise within the workforce.

8. December 2018 onwards: allegations and management of risk

8.1 The third allegation/incident involving Craig was in December 2018- a referral was received from a member of staff at the Children's Home to Tameside Children's Service. It was forwarded to the Police that child A had written in his diary, which has been seen by a member of staff, that he was approached by a 16-year-old resident male Z who asked the 11-year-old to expose himself and that he would also expose himself. He further alleged that Craig has also asked him to expose himself. This review has been provided with notes from Stockport children's services that are understood to be notes of what is titled 'strategy discussion' which took place early in December 2018, but it has no heading identifying which agency/authority undertook these recordings. These notes record that two out- of-hours social workers from Stockport attended the Children's Home, accompanied by two police officers from the PPIU from Greater Manchester Police, and a member of the Children's Home staff. As it was a Sunday none of the management team at the Children's Home were on site.

8.2 All four resident boys were discussed, and child A was spoken to by two Police officers. The record outline that the member of staff at the Children's Home considered the following 'all the four children that reside at this care home are very closely monitored, they don't get the opportunity to do anything without them knowing as there are four members of staff for the four children, always one to one and they are always monitored if the children are together in the lounge or chill room. The staff member stated that child A is 'very dramatic' and believes that if this had have happened, the member of staff would not have been far away and would have either heard it, heard A shout "No". The staff member further informed that the child A did not have a clock in his room, and he cannot tell the time.

8.3 The Police learning summary outlines a 'crime should have been recorded, and an outcome, if there was insufficient evidence to prove or confirm it having occurred ought to have been the correct disposal'. There was also evidence of crimes having been committed in relation to the 15-year-old who Z Facetimed and for searching the internet for indecent images (also an offence). Z later admitted to in his AIM assessment interview. This investigation did not accord with Police guidance set out in the national crime recording standards (NCRS) for disposal of cases.

8.4 The review was provided with evidence of emails from London Authority 1 Children's Services to the Children's Home to enquire whether a strategy meeting was being set up. Although it would not have been the Children's Home's responsibility to convene a meeting, they did have a level of responsibility to see that it took place so that the allegations of crimes could have been evaluated by the police and local authority. GMP did not make contact with London Authority 1 following the December 2018 strategy meeting as this rested with the host authority. After London Authority 1 made direct contact with GMP in January 2019, it appeared that the police log was close, and would be re-opened, if London Authority 1 were to re-contact. The incident was classed as no further action (NFA) pending contact from London Authority 1. In an email exchange between the London Authority 1 social worker, requesting an update of the Police investigation, to the home's manager, the reply was: 'the police came and spoke to the young person however said that this was not going to go any further, due to nothing happening'. London Authority 1 assumed from this (incorrectly) that the investigation had been closed and that the Children's Home manager had said that 'nothing happening'. There followed another email from the Practice Manager in London Authority 1 to the home's email address stating the following 'Can you please arrange a strategy meeting as this is abuse from one child to another, the other Local Authority need to be involved in this meeting to consider the needs of their child'. What then happened was that the strategy meeting was not responded to by Stockport, the Children's Home and GMP as well as placing authorities' children's social workers and the focus became undertaking an AIM assessment for Z. Whilst this was one of the agreed actions of the strategy meeting of the in December it sat equally alongside the other recommendations.

8.5 The view from the Provider 1 senior managers was the member of staff who attending the strategy meeting was not sufficiently senior to attend such a meeting and the Police and local authority (Stockport) who chaired this meeting should have scrutinised the seniority of their attendance. This would not an appropriate request and this should be resolved through the Provider 1 senior management escalation process. Also, their view was influential in that the Police and Stockport attending social workers were assured to the immediate safety of the children resident at the time of the meeting and considered that the risk management plans outlined by this staff member was sufficient.

8.6 In the following days the unit manager for the Children's Home informed London Authority 1, in an email, that whilst the AIM assessment was being set up there was 1:1 in place for all the children so that they, and Z, would be safe. There was also assurance given that all social workers had been informed

and that there were alarms on the doors of each child's room so the staff would be alerted to any disruption.

8.7 Analysis and recommendation-A cross boundary strategy meeting was not responded to by Stockport local authority that held the responsibility to set this up. Notwithstanding this Tameside, and the Children's Home, should have pursued Stockport for this given both are within the GM boundary and work to these safeguarding procedures. Tameside, London Authority 2 (for child A) and the Children's Home, could have escalated this matter. The failure by Stockport to send out formal minutes of the meeting of 2nd December, and the actions arising from it, contributed to this not being progressed.

8.8 The subsequent effort made by placing authorities to access the information that was discussed at the strategy meeting in December was not made to the host authority but to the Children's Home. Stockport did not exercise its responsibilities in sharing the information from the strategy discussion to other Local Authorities. There was no clarity about who was holding the process together and at no point was the GM procedures made reference to. This was, therefore, not a lack of procedure, but a lack of clarity and appreciation of who was leading on bringing the strategy meeting together. Whilst the strategy minutes were only sourced for this review, and not in a formal format, the actions for calling a wider strategy meeting with all local authorities with placed children in the Children's Home was correct and follow GMP safeguarding procedures.

8.9. There was no joint evaluation of the risks that Z posed to the other children which would include any risk management plan that the Children's Home had put in place. The views recorded by the member of the Children's Home staff who attended the strategy meeting do not represent a neutral position and reduced the likelihood of the children's evidence to be given without prejudice of disbelief. At the strategy meeting the Children's home staff member understood that the allegations were not founded as 'the story changed a number of times' and the Police were content with what the home had in place with regard to 1:1 supervision. Even with the staff oversight and 1:1 ratio it is possible that children could be exposed to risk and other alternatives should have been considered had all the local authorities known the full extent of the risk involved. Equally, the police did not follow the correct procedures whilst investigating the disclosures made by A and other disclosures that were raised at the strategy meeting were not investigated further.

> **Recommendation 12)** Stockport children's services should review their procedures to ensure they support compliance with GM safeguarding procedures for children placed in their authority by other local authorities with specific reference to holding strategy meetings as the host authority.
>
> **Recommendation 13)** TSCP should ensure that there is a review of the use of GM procedures with regard to the management of children, who have sexually harmful behaviour, placed in children's homes.
>
> **Recommendation 14**) Provider 1 should ensure that their staff are compliant with GM procedures for children placed in their children's homes with specific reference to children who exhibit sexually harmful behaviour. This includes the conduct of staff that are reporting and supporting children who may become witness for a criminal offence so that they do not impede the opportunity for children to become a witness. Provider 1 must ensure that a senior member of staff is present or called upon when statutory agencies are attending a home and ensure that the Registered Manager follows up with all agencies and seeks clarity as to responsibility in relation to all safeguarding events.
>
> **Recommendation 15)** GMP must ensure there is compliance with NCRS in relation to the recording of 3rd party reports of crime (in relation to child-on-child sexual abuse) is followed and that subsequent crimes or crime related incidents are recorded where appropriate.

9. Post strategy meeting December 2018

9.1 Following the allegation London Authority 1, and the Children's Home, engaged in an agreement about the commissioning and conduct of the AIM 2 assessment. However, there was some delay. The expectation at Provider 1 was that London Authority 1 would commission an independent qualified assessor to come to the Children's Home to undertake the assessment. However, London Authority 1 did not immediately confirm funding for the assessment. This caused some concern by Provider 1, who eventually insisted to London Authority 1 that the assessment had to be commissioned or Z might not

be able to remain at the Children's Home. London Authority 1 confirmed funding in March 2019 but was then unable to find someone who would be able to undertake the assessment. This led to Provider 1 offering to undertake the assessment itself, as a separate specially commissioned piece of work.

9.2 During this time London Authority 1 had asked for a risk assessment for Z whilst the AIM 2 was being set up. It is not clear what was provided to London Authority 1 other than what was set out at the December strategy meeting of 1:1 and staff being vigilant about the behaviour of Z towards the other children.

9.3 London Authority 1 shared this AIM 2 assessment for this review, and it outlines a number of incidents, referred to in the strategy discussion in December 2018.

9.4 The AIM 2 assessment was conducted by a Specialist Advisor employed by Provider 1 who specialised in assessments of children who exhibit harmful sexual behaviour and who was not involved in the care and therapy of either Craig or Z. This Specialist Advisor was supported by the therapist who had been working with Z and Craig on the psychologically informed process therapy at the Children's Home. The reviewer considered this to be a conflict of interest as they had been working with the children (Craig & Z) in their therapeutic recovery and Craig psychologically informed process notes that the focus of the work was on the basis of Craig making 'unfounded allegations'. Provider 1 now accepts that it was not ideal that the therapist had had prior involvement with Craig and Z, but the therapist was not leading on the assessment (they were supporting the Specialist Advisor) and this appeared to Provider 1 to be the best way to move on with the assessment which was already delayed.

9.5 In this interview assessment for the AIM 2 undertaken with Z he admitted that he had searched on the internet for 'babies and children and that he was sexually attracted to them'. He also admitted that the incident in December 2018 had actually happened and that the other incident of exposing himself to a pupil at school in July 2018, which he initially denied. He also admitted to searching for brothers and sisters having 'sex' on the internet. It states that the specialist assessor visited Z at the home and Z admitted to the allegation involving child A. This admission to the therapists was not passed onto the Police, or the social worker for child A. Significantly this changed position via Z's admission, did not filter through to any of the children who had made allegations about Z, and the therapy that Craig was continuing to have did not alter the view that he was making 'unfounded allegations' as the same therapy continued on this basis.

9.6 The view of the Provider 1 assessors was that there was much to work with as Z had admitted to his behaviour but showed no remorse. The concluding comments within the AIM 2 were 'whilst Z does have a strong team of caring professionals supporting and supervising him on a day-to-day basis, he is liable to take the opportunity when he can to explore his inappropriate problematic sexualised behaviour. This reflects Z's lack of internal inhibitors that would prevent this risky behaviour'. His overall risk was considered to be medium. 'An outcome of MEDIUM supervision level suggests that Z requires a moderate level of supervision and a full programme of therapeutic intervention. This will often mean that he can remain living in his local community although some restriction of his activities may be required if he is risk related (e.g., offer access to potential victims, exacerbate concerns)'.

9.7 London Authority 1 and the Children's Home received this AIM 2 assessment, but the identified risks were not shared with the other placing authorities' social workers. Provider 1 considered that because the assessment was commissioned by London Authority 1 that it was for them to determine how it should be shared. This is a misunderstanding about the Governments 'Information Sharing' protocol (July 2018) for safeguarding children. When there is an identified risk the information must be shared, and London Authority 1 and the Children's Home needed to consider how this was going to be progressed. The national guidance requires agencies to share information that identifies a risk to children in order to protect other children. Whilst London Authority 1 had ownership of the AIM Assessment that does not confer exclusivity and the Children's Home did not feel it had the authority to share London Authority 1's commissioned assessment report. By not sharing the assessment of risks it identified, it did not give the respective social workers an opportunity to consider whether they were prepared to continue with their children in the placement. This is a misunderstanding about information sharing and action should be taken to remedy this misunderstanding.

9.8 The chronology from Provider 1 outlines that 'Z had in place a risk assessment for sexualised behaviours that states that Z was not to be left alone with any young person at any time and to have no unsupervised time with any other young person'. The date of this was September 2019. It also states 'The risk level is recorded as 5 (Catastrophic Consequence and Rare Likelihood). A rare likelihood

indicates that the risk is 'Highly unlikely but may occur in exceptional circumstance. It could happen but probably never will.' The Children's Home learning summary states that in the opinion of Provider 1 young people at the Children's Home were well supervised and that dynamic risk assessments were always undertaken prior to any young people going out or socialising together which minimised the opportunities for sexually harmful behaviour. These dynamic risk assessments were not always recorded. Provider 1 has confirmed to the reviewer that these dynamic risk assessments are conducted in the moment, in addition to the formally recorded risk assessments. The review was concerned about these unwritten assessments as being not recorded as it therefore cannot be followed easily by each staff member if they are not written down and fully understood.

9.9 Analysis and recommendations- The Children's homes are guided by statutory guidance from the Department for Education Guide to the Children's Homes Regulations and the quality standards (2015). This requires the management of children's homes to work to the 9 standards outlined in the guidance. The standard for safeguarding and managing risk states the following 'Registered persons should seek to involve the local authority and other relevant persons whenever there is a serious concern about a child's welfare. They are also required by regulation 40 to notify placing authorities, Ofsted and other relevant persons about serious events. Serious events include an allegation of sexual abuse of a child by another child. The Children's Home did make the necessary Regulation 40 notifications in this case. In addition, the conduct of the therapy assessors must be bound by safeguarding reporting and referring procedures which in this case did not occur.

> **Recommendation 16)** Provider 1 must take steps to develop information sharing protocols throughout its services with regard to when and how information of risk is shared with respective placing authorities. This should reflect the national information sharing protocol issued by the Government and take into account immediate risk and assessed risk either identified through reports or and assessment processes.
>
> **Recommendation 17)** Provider 1 must ensure that their therapist comply with national safeguarding standards/procedures for reporting and recording allegations of abuse within their direct work with children.

10. 2019 management and progress of Craig

10.1 Craig reportedly settled in 2019 at the Children's Home and consequently in early 2019 the IRO (Independent Reviewing Officer) endorsed the exploration of Craig transitioning back into foster care where he would have the opportunity of experiencing family life. An assessment for this was complete in September 2019 recommending that Craig move into foster care. A foster placement was identified and a transition plan for this developed to begin in December 2019. With regard to school Craig was making secure gains towards accessing KS2 SATS but there was an on-going concern that Craig was still struggling emotionally and recorded by school he could 'be involved in fabricating stories about other students to gain attention'. There continued to be co-ordination between therapist, school and home to address and offer 'toolkit of self-regulatory strategies' from the psychologically informed process therapeutic work. Craig was having some contact with his father and grandmother and limited contact with his mother as she had moved. The February 2019 statutory care review made no mention of the safeguarding investigation by the police in December 2018 and the IRO did not know of the concerns that were expressed in these allegations. The Children's Home also did not mention the circumstances of the December allegations at the review. As already outlined, there were not minutes sent out from this strategy meeting and therefore not uploaded onto the child's file. The social worker and the Children's Home should have included this in their update reports, both written and verbal, for the review and it is a significant omission. Significant events, such as that occurred in December 2019, are examples of these. The IRO also should have reviewed the child's electronic case records to ensure that any events or changes of circumstances were included in the subsequent review. The IRO called an earlier review in January 2020, following the allegation of rape by Z on Craig, to review his planned placement move. Of note there is no record of the Police investigation regarding the allegation of rape that took place in December 2019 which is a further significant omission.

10.2 Despite what is now known to have been happening during his period at the Children's Home Craig had made some progress in school and had attended all his medical appointments. In a regulation 44 visitor report required monthly through the requirements in 'The Children's Homes (England) Regulations (2015)' Craig's grandmother is reported to be very content with his placement and found

the staff always treated her respectfully with contact maintained. However, this does not mitigate the lack of professional attendance to the allegations Craig made.

10.3 The final safeguarding incident occurred when the children from the Children's Home went to an outdoor leisure complex in December 2019. Both boys, Craig and Z, went out of sight of the staff in the complex. The staff member searched for them and went to the male toilets and when asked where Craig was Z shouted that he was on the toilet and Craig was not in the toilet. Craig and Z were seen coming out of the toilet and when back at the Children's Home Craig stated that Z had raped him. The Police were contacted, and Craig was taken to the Sexually Assault Rape Centre (SARC) when forensic swabs were taken. The criminal investigation is still on-going. Craig moved to a foster placement in March 2020 and Z moved following the allegations in December 2019.

> **Recommendation 18)** Tameside Children's Service Independent Reviewing Officers must ensure that the statutory reviews for looked after children reflect, and include, details of any new safeguarding allegations/concerns from the child's placement especially those that are subject to criminal investigation.
>
> **Recommendations 19)** Social Work reports to statutory reviews must include any update on safeguarding allegations/concerns and the progress of any criminal investigation to inform care planning. Tameside children's services must ensure that is this is complied with as outlined in statutory guidance.

11. The risk posed by child Z-background information provided by London Authority 1

11.1 The young person (Z) who is alleged to have assaulted Craig was a child placed by London Authority 1 in 2016 in the Children's Home in Stockport. He was 14 years old at this time. There is no specific allegation of any sexualised behaviour from Z on the file prior to puberty. However, there were significant concerns regarding his behaviour. Behaviours included, self-harm behaviours, aggression towards siblings and on occasions, peers at school, hyper-activity, impulsivity, obsession with fires and lighters and concerns generally about how he related to others and his emotional state overall. At primary school he was provided with 1:1 supervision to manage concerns. Concerns were regarding previous sexualised behaviour with his sibling and his self-report that he had been sexually abusive. This presented risks of sexual harm that he could pose. This concern was shared with his placement and informed decisions included additional commissioned therapeutic input for Z. The Children's Home learning summary describe Z was 'emotionally much younger than his chronological age' and functioning at a much younger level. When he was placed at the Children's Home, he was the second oldest of the four children living there (and he was the oldest by the time of the events in December 2019). Clinical therapeutic support, including quarterly reporting, was also commissioned for Z at the placement. In addition, in May 2019, following a number of incidents indicating sexual harm to other children, an AIM 2 (Assessment, Intervention, Management) assessment was completed in respect of Z. The outcome of this assessment was used to determine the level of supervision that is required. Z was receiving ADHD medication reviews from HYMs and also seen by the looked after children's health team for annual health assessments. The health professionals involved in Z's care were unaware of the escalation of behaviour, allegations or risk assessment and plans in place. Whilst this review is not specifically focussed on Z's care plan it does denote a fragmented approach to involvement of other agencies in the care and risk assessments.

11.2 The assessment concluded that Z presented a medium level of risk of future harmful sexual behaviour and required a moderate level of supervision. There were several allegations made against Z whilst he was resident at the Children's Home, first dated in September 2016 when the Children's Home manager noted that Z and another child had a sexual interaction' although it is not stated what the allegation was the chronology states 'reporting' had taken place. London Authority 1's learning summary does state that there were concerns expressed about Z's risk to a sibling following allegations that he had 'raped' them. These risks were included within the referral information to the Children's Home outlined in London Authority 1's learning summary. The staff at the Children's Home considered that the risks were manageable with additional therapeutic input which was undertaken by the therapist through the psychologically informed process. Given the frequency of the allegations made against Z a 1:1 model of risk management was not likely to prevent his 'opportunistic' nature of problematic and

deviant behaviour. There are alternative models of risk management which London Authority 1 could have been explored for the placement of Z which include a single agency placement with only adults such as a single foster placement. Whilst these are difficult placements to source, they are commonly used in placement procurement because of the level of risk that a child such as Z posed. This would also need to be a consideration for the children's home in their matching process for any new placements as the home is not only matching that index child to the placement.

11.3 London Authority 1's learning summary notes that the AIM 2 risk assessment had underestimated the level of threat L posed to other children. They also considered there were missed opportunities to bring the multi-agency group together to consider these risks following the allegations made against Z. As outlined in this review having a cross boundary risk management meeting would have put in place, at the very least, an opportunity to review all of the children and emerging risks. In terms of general practice London Authority 1 commissioning service are exploring an 'approved' AIM assessment provision for children in order to obtain a list of approved assessors. The lack of an approved list of assessors combined with a delay in internal processes to approve this requested assessment resulted in a delay in this taking place. London Authority 1 also did not specify how the AIM 2 assessment would be shared with the Children's Home which resulted in the risk not being shared with the wider placing authorities.

12. London Authority 1 children's services learning-

a) Training will be commissioned in order to support a deeper understanding of the 'weight' to be applied to recommendations following AIM assessments as all staff involved in this process were led by this recommendation which, in hindsight, turned out to be incorrect.

b) In addition to this, there were concerns in relation to the continuous change of social worker which provided a lack of continuity in terms of relationship and assessment of risk. Strategies to support retention for social work staff within the looked after children's service have been put in place in terms of organisational systemic change that has been brought in by the new leadership team to reduce the frequency of changes to children's cases.

12.1 There was also a lack of evidence that London Authority 1 had received and recorded updated risk assessments following each incident/allegation and the frequent change of social worker is likely to have played some part in the information exchange.

c) There is learning in terms of the need to ensure that therapeutic reports and updated risk assessments are received and considered as part of on-going, overall risk assessment in relation to Z.

d) The commissioning and sharing of risk information such as in the AIM assessment requires the authority to consider how reports of such nature are shared with any placement and with authorities who have placed children but should be guided by the national information sharing guidance.

13. Key learning in relation to this case

13.1 On the basis of understanding of sexual abuse disclosure, new strategies for interviewing children have been developed with the aim of enabling children to disclose abuse more easily. There is now a substantial body of literature on forensic interviewing, and an emphasis on the importance of having specially trained interviewers in police and social work services available to undertake this work with a good enough understanding about helping children disclose information and being sufficiently well informed about current guidelines for interviewing. The evidence from this review detailed those people receiving and overseeing the allegations did not have this level of knowledge and insight or at least did not apply it sufficiently well to be effective.

13.2 Accurate figures for the extent of harmful sexual behaviour (HSB) do not exist, not least because HSB covers such a broad spectrum of behaviours, most of which do not come to the attention of the authorities. However, in one UK study lead by Martin Hackett, Durham University entitled 'Young people who display sexually harmful behaviour' (2018), two-thirds of the contact sexual abuse experienced by

children and young people was perpetrated by other young people, and recent figures show an increase in reports to the Police alleging sexual offences committed by young people against other young people. The Centre of expertise on child sexual abuse (CSA) in the UK comment in their key messages on research 'most sexually abusive acts are perpetrated by young people who have other major difficulties in their lives such as prior experience of physical or sexual abuse or neglect, witnessing domestic violence, a lack of positive male role models, or having parents with mental health or substance abuse issues'.

13.3 What we know is that abusers will not disclose information; they will seek to conceal their behaviour and will seek to divert or undermine detection of their behaviour. In this review there was a shared view that the subject of this review (Craig) was making 'unfounded allegations' as the professional network were influenced by the perceived impossibility of the perpetrators' ability to carry out these actions. There was a strong belief that the protective net (risk assessment measures) that was put in place in the care home was impenetrable which excluded the possibility of abuse taking place. This led to a false belief that if there was a risk that it could be countered by the measures in place and that Craig's allegations were then deemed to have no veracity or believability.

13.4 It was known to the professionals involved with Z that he posed risks of harmful sexual behaviour. Risk management measures were put in place which were considered to be adequate; however, these did not mean that he would never be left unsupervised even for short periods of time. In the event Craig described Child Z using an opportunity to commit an offence against Craig whilst they were unsupervised in December 2019.

13.5 The complexity of this case was compounded by the fact that both perpetrator and victim were children in the care system and had themselves had traumatic and disruptive early experiences in their own families. Their status required them to have additional support, high levels of need with equally high levels of staff vigilance. This was provided by the residential home and additional costs were picked up by the respective local authorities, but this should not equate to a belief that abuse by another resident child could not take place as this in itself poses a risk.

13.6 Strategic leaders must create a context in which practitioners and front-line staff are better equipped and supported to make effective and timely responses to children in care with the most complex needs. Safeguarding Partnerships have responsibility not only ensure that there are good procedures are in place but that they are adhered to. Auditing and reviewing processes should be a regular part of any review cycle to ensure what is put in place is being undertaken.

13.7 Children cared for by the local authority with the most complex needs tend to be placed outside of the geographical area as the resource required is not always available to meet their needs. The means that they are displaced from their families and continuity of local services can be difficult to engage and often there are waiting lists. Whilst in this case the geographical distance was not an immediate barrier to services it was outside of the local authority boundary which meant transferring services such as ADHD and medication can have in built delays and new professional connections for the care planning system.

14-Good practice identified within this review.

14.1 When Craig raised the final allegation of rape in December 2019 all agencies responded to this within good practice standards and speedily. Craig was taken to have medical attention, required for criminal evidence and also his well-being. A decision was made, correctly, that both boys could not stay within the home as there was a criminal investigation being conducted and Craig remained in the placement until a foster placement was identified. He moved shortly after in January 2020. There was a care planning review which identified that the care plan for foster care was to be expedited and this took place in response to the criminal investigation and allegations. Craig's parents were informed of the events that took place, and whilst both in prison, there was communication with the social workers.

14.2 Craig's regular routine medicals and contact were always adhered to and whilst this review revealed that all partner agencies were not involved in every cared for review in this placement his general medical care was well attended to. Contact with his family was always addressed and whilst there were difficulties in putting this in place because of his parents being available because of their incarceration other means had been put in place to make sure that this took place through digital means. This area of family contact is very important to Craig and he continues to respond well to contact which has been maintained.

Recommendations by organisation

Tameside Children's Service

Recommendation: 1) Tameside Children's Services should review their procedures/practice standards in relation to the placing of children in emergency placements. This should include reviewing the commissioning process being developed to ensure that impact risk assessments are being conducted and shared appropriately with placing authorities.

Recommendation 4) Tameside children's services should ensure there is a system in place for informing partner agencies when children are placed in emergency within 5 days by the placing social worker. This must involve notification processes to other agencies involved. This should be via telephone if outstanding needs or specialist services are involved.

Recommendation 6) Tameside Children's Service should review the role of the social worker in joint investigations so professional expertise is exercised with regard to allegations which are considered to be unsubstantiated and or false.

Recommendation 8) Tameside Children's Service Independent Review Service should ensure that reviews of children looked after include a full account of any therapeutic input and the how it integrates with the care plan. It must also include any updates on allegations/safeguarding concerns raised. The efficacy of any such therapeutic work should be reviewed by this forum.

Recommendation 18) Tameside Children's Service Independent Reviewing Officers must ensure that the statutory reviews for looked after children reflect, and include, details of any new safeguarding allegations/concerns from the child's placement especially those that are subject to criminal investigation.

Recommendations 19) Social Work reports to statutory reviews must include any update on safeguarding allegations/concerns and the progress of any criminal investigation to inform care planning. Tameside children's services must ensure that is this is complied with as outlined in statutory guidance.

Tameside Safeguarding Children Partnership

Recommendation 5) TSCP should ensure that GMP and Tameside Children's Services should review the recording and management of section 47 enquiries when children raise allegations of abuse so that they meet Working Together requirements and that there is management oversight and sign- off.

Recommendations 11) TSCP should review the training for staff that are responsible for conducting investigative interviews with children to ensure that there is sufficient skill and expertise within the workforce.

Recommendation 13) TSCP should ensure that there is a review of the use of GM procedures with regard to the management of children who have sexually harmful behaviour placed in children's homes.

Provider I

Recommendation 2) Provider 1 should further develop their impact assessment to ensure that it identifies the children who have harmful behaviour and a risk to other children with clear mitigations in place. This should include how this is shared with other placing authorities, including in writing.

Recommendations 3) Provider 1 should ensure that they seek clarification from the placing authority with regards to the arrangements for holding the 72-hour placement review so that the correct information is gathered, and the child's needs are assessed appropriately.

Recommendation 7) Provider 1 should ensure that Head teachers and teaching staff are aware of their role and responsibility, in the event that they have to report and support a statutory safeguarding investigation involving children/pupils within their schools. In particular, Provider 1 must ensure that staff report directly themselves and not assume that other agencies are reporting concerns.

Recommendation 9)) Provider 1 must ensure that risk management plans that are put in place by a children's home should be reviewed by the statutory reviewing function and not solely by the children's homes own staff.

Recommendation 10) Provider 1 should review the training for their staff with regard to children who disclose abuse: specifically, the role of residential workers.

Recommendation 14) Provider 1 should ensure that their staff are compliant with GM procedures for children placed in their children's homes with specific reference to children who exhibit sexually harmful behaviour. This includes the conduct of staff that are reporting and supporting children who may become witness for a criminal offence so that they do not impede the opportunity for children to become a witness. Provider 1 must ensure that a senior member of staff is present or called upon when statutory agencies are attending a home and ensure that the Registered Manager follows up with all agencies and seeks clarity as to responsibility in relation to all safeguarding events.

Recommendation 16) Provider 1 must take steps to develop information sharing protocols throughout its services with regard to when and how information of risk is shared with respective placing authorities. This should reflect the national information sharing protocol issued by the Government and take into account immediate risk and assessed risk either identified through reports or and assessment processes.

Recommendation 17) Provider 1 must ensure that their therapist comply with national safeguarding standards/procedures for reporting and recording allegations of abuse within their direct work with children.

Stockport Children's Service

Recommendation 12) Stockport Children's services should review their procedures to ensure they support compliance with GM safeguarding procedures for children placed in their authority by other local authorities with specific reference to holding strategy meetings as the host authority.

Greater Manchester Police

Recommendation 15) GMP must ensure there is compliance with NCRS in relation to the recording of 3rd party reports of crime (in relation to child-on-child sexual abuse) is followed and that subsequent crimes or crime related incidents are recorded where appropriate.