Local Learning Review

Presented to the Tameside Safeguarding Children Partnership on 7th March 2022

Re: **Ben and Alex**

Independent Reviewer: Allison Sandiford[1]

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the TSCP

[1] Allison Sandiford was appointed as the Reviewer. She is an experienced reviewer, entirely independent of the TSCP.

Contents

1 Introduction and Methodology

1.1 This report covers the findings and recommendations of a Children's Learning Practice Review relating to two children referred to as Alex and Ben[2].

1.2 Following a Rapid Review[3] process and consultation with the National Panel, the Tameside Safeguarding Children Partnership (TSCP) identified that lessons could be learnt regarding the way that agencies work together to safeguard children and commissioned this Local Child Safeguarding Practice Review.

1.3 A multi-agency review panel consisting of representatives from the Clinical Commissioning Group (CCG), Pennine Care, Children's Social Care (CSC), Greater Manchester Police (GMP), Youth Justice, Tameside and Glossop Integrated Care Foundation Trust (TGICFT), Education, and Early Help met on the 7th June 2021.

1.4 The panel considered the scope of the review and recognised that much work had been undertaken by agencies and practitioners with both children. However, although reference will be made to historic/post-scoping instances where relevant to current working practices – the review will predominantly focus upon the following periods which encompass the incidents that led to the review.

Child	Date from	Date to
Alex	4.4.19 - allegation of peer abuse	17.2.21 - strategy meeting
Ben	24.10.18 - 30 weeks gestation	26.9.20 - hospital discharge

1.5 The panel agreed the Terms of Reference[4] and additional information was requested from the agencies involved to aid the review process.

1.6 The panel further met on the following dates to monitor the progress of the review and discuss the learning:

Panel 2: 2nd September 2021
Panel 3: 22nd October 2021
Panel 4: 20th December 2021

1.7 Learning Events were held on the 29th July 2021 and the 17th September 2021 to discuss the circumstances around Alex and Ben respectively with frontline workers. The events were attended by a wide range of agencies, and feedback from the participants generated positive discussion around areas of practice that could be developed and improved. This feedback has formed the basis of the recommendations of this report.

1.8 It is not the review's intention to disclose detailed family information in this report[5] - only the information that is relevant to the learning established. However family engagement is of huge benefit and the reviewer would like to thank Child Alex and her mother for their contributions. The decision of Child Ben's family not to contribute to the review is understood and respected.

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[2] Pseudonyms are used to preserve the anonymity of the children and their families.
[3] A rapid review is undertaken in order to ascertain whether a Local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made by the national *Child Safeguarding Practice* Review *Panel.*
[4] Refer to Appendix 1
[5] Statutory Guidance expects full publication of local child safeguarding practice review reports, unless there are significant and justifiable reasons why this would not be appropriate. It is important to ensure the anonymity of the families within this report.

2 Summary of the Cases Subject to Review

Child Alex

2.1 Alex has been known to Children's Social Care since birth. In July 2010, she and her siblings were made subject to child protection plans due to concerns around domestic abuse, parental drug use and neglect. In November 2011, when the risks had reduced, the protection plan was discharged and the children were supported with Child in Need. The case closed in July 2012.

2.2 After a period of approximately two years, agencies began to raise new referrals to Children's Social Care. Early Help support was offered but engagement was said to be limited and the support elevated to child protection again in March 2017 for a period of 8 months. Child in Need followed for a 7 month period. During this time, Alex's friends reported that she had forced them to undress and touch themselves intimately. This was reported to the police and is recorded. Early Help services continued until January 2020.

2.3 In December 2020 school's attention was brought to a photo of Alex which was being circulated on social media and showed an older teenage male with his hands placed down her trousers. School contacted Alex's parents and advised that they contact the police. Later that day school was informed that Alex had told a friend that she had been raped several years ago by her babysitter (an adult male). School made a referral to Children's Social Care which included both sexual assaults.

2.4 Police received a report of the social media incident and attended Alex but she did not wish to provide an interview. In January 2021 the police contacted Children's Social Care to inform them that the sexual assault was to be filed. It then came to light that the police had not been told of the historic allegation.

2.5 On the 3rd February 2021, Children's Social Care convened a Child in Need (CiN) meeting with school, health professionals and parents and a plan was formulated to support the family.

2.6 Following police update regarding the historic allegation, a strategy meeting convened. Agency representatives at this meeting concluded to progress to an Initial Child Protection Conference.

2.7 Alex was subsequently made subject to Child Protection under the category of neglect.

Child Ben

2.8 Professionals have had longstanding concerns relating to Ben's mother's ability to meet the emotional and developmental needs of her children. Concerns have included domestic violence, transient lifestyle, drug use, mother's poor mental health, inappropriate carers, and anti-social behaviours in the home.

2.9 Ben and his siblings all have chronic developmental delay due to neglect and in June 2019 the children were made subject to child protection plans. Ben's plan was discharged in July 2020 when mother was reported to have made the necessary changes. He continued to be managed under Child in Need.

2.10 In September 2020 mother attended A&E with Ben. She said that she had noticed that he had not passed urine overnight and that his penis was swollen. Further examination uncovered multiple bruising to his ear, neck, thighs, and penis. Some of the bruising was concluded to be non-accidental, including the bruising to his penis.

2.11 Ben was admitted into the hospital and he and his brother were subsequently placed with foster carers and made subject to Interim Care Orders.

3 Common Themes

During discussions with panel members and professionals at the respective learning events, around the circumstances of each child and the terms of reference, thematic issues were recognised. This section of the report looks at these themes and reflects the views of frontline practitioners, panel members and family contributors.

3.1 Strategy Meetings

3.1.1 Statutory guidance in Working Together 2018 prescribes that a strategy discussion should take place *wherever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm.* The discussion can be in the form of a meeting or a phone call, and more than one discussion may be required, but it should involve Children's Social Care, the police, health practitioners and other bodies such as the referring agency or a school or nursery. Importantly the strategy discussion can take place at any time whether immediately following a referral, during an assessment or if new information is received on an already open case.

3.1.2 With regards to Alex, neither a strategy discussion or a strategy meeting convened immediately following referrals to Children's Social Care from school and the police. Instead, after screening and triaging, the Multi Agency Safeguarding Hub (MASH) sent the referral directly to Children's Social Care. It has been established that this decision was borne from the circumstances presenting as confusing and the MASH worker concluding that it would be helpful for a social worker to attend Alex to establish the facts, hear her voice and decide thereafter whether a strategy meeting was required. Unfortunately following the social worker meeting with Alex, consideration of a strategy meeting was overlooked and consequently, no strategy meeting convened.

3.1.3 It is recognised that at the time of this oversight, there was added pressure on workers due to staff absences[6] but to reduce the chances of such an oversight going unnoticed in the future, Children's Social Care have embedded earlier case oversight by team managers into practice.

3.1.4 Two months later after the police had shared with Children's Social Care that they had no knowledge of the historic rape, a strategy meeting was held. Although Child in Need meetings had already been convening, professionals noted that the strategy meeting proved crucial as it was then agreed necessary to progress to an ICPC.

3.1.5 The decision to hear the voice of Alex before progressing to a strategy meeting was discussed in depth by practitioners at the Learning Event and it was concluded to have been a justifiable decision with merits. But upon reflection, an immediate strategy meeting would have been beneficial to pull together all of the agencies information. This would have effected all of the professionals being made aware of

[6] This has now been addressed and is no longer the case.

both of the sexual assault allegations and allow for the production of an appropriate multi-agency action plan.

3.1.6 The MASH worker's actions indicate that they were looking for clarification of harm, and the decision to do this prior to a strategy meeting, raised discussions about whether practitioners may be under a misconception that *proof* of harm is required to convene. This is untrue - a concern of a risk of harm is sufficient and there are benefits to early information sharing in the event of a case progressing.

3.1.7 Professionals at the Learning Event all agreed that in the case of Alex, an immediate strategy meeting could have been used to discuss and decide how information about the sexual assaults was to be gathered[7] and shared. But it was noted that although everyone was in agreement with that course of action now - there had been no professional or agency challenge at the time. Education and police, as the referrers, could have requested a strategy meeting within their referrals. And as both agencies would have expected an invite, both would have been aware of the strategy meetings omission. It was agreed that it is possible that some professionals subconsciously acquiesce to the experience of the MASH and/or Children's Social Care when deciding whether a strategy meeting should convene. Further training regarding strategy meetings would equip professionals with the confidence to request a meeting and/or appeal a decision to delay one.

3.1.8 Timely strategy meetings were identified within the case working of Ben and professionals at the Learning Event demonstrated good knowledge of their aims and expectations. But there was discussion around a possible missed opportunity to convene when concerns for Ben's environment heightened in early 2020. The social worker discussed how she had conducted an unannounced visit and found several young adults at the address, a deterioration in the home conditions, and Mother absent.

3.1.9 The social worker explained she hadn't initiated a strategy meeting because a conference was already planned for the following week. She said that she now reflected that there may have been benefits to a strategy meeting being held as a strategy gets straight to the point in terms of what each person is going to do with immediate effect. The chair of the conference agreed but some professionals said that, in their experience, police can be reluctant to convene a strategy meeting when the subject is already in the Child Protection system and will question what the purpose is. The police agreed that they question the purpose of some strategy meetings but explained that the questions did not represent a reluctance to convene. They were posed in order to establish the rationale of the meeting for the attending officer; to help them to prepare effectively.

3.1.10 A strategy meeting convened appropriately when Ben attended A&E with his bruises but a further follow-up/discharge strategy meeting did not convene. This has been established to be because the social worker had updated staff that a legal meeting had been held and the decision to remove Ben under Section 20[8] had been made, hence staff knew that Ben was being safeguarded. This decision is further considered later in the report.

3.1.11 **Lesson 1:**

[7] For example, it may have been decided that it could prove more effective practice to ask a professional with whom DE had a trusted relationship with to hear her voice in the first instance.

[8] Section 20 of the Children Act 1989 sets out how a Local Authority can provide accommodation for a child

Professionals from all agencies did not have a good enough knowledge of strategy meetings or recognise their positive effects upon case progression.
GMP have produced PowerPoint training that includes strategy meeting roles and responsibilities. It has been agreed that this training will be shared with other agencies for dissemination. This will address this learning point.

3.2 Graded Care Profile

3.2.1 Both Alex and Ben were subject to a Graded Care Profile[9] (GCP). The GCP is based on psychologist Abraham Maslow's hierarchy of needs. It allows practitioners to explore four areas of care – physical care, safety, love, and esteem – and to consider the parenting, which is observed against simple predetermined criteria. The results of the assessment are entered on to a summary sheet which identifies areas of deficit and helps professionals consider the support and intervention needed.

3.2.2 Alex was subject to a GCP following the strategy meeting in February 2021. It was undertaken by the social worker who scored the piece of work with the family and then scaled it. However good practice would be to share it with various agencies as it is expected that they provide input also. It was established at the Learning Event that education had not contributed to Alex's GCP. Given that they were undoubtedly the agency with the most knowledge of Alex and her family, this is a big omission that will have affected its quality.

3.2.3 During discussions about how timely support was for Alex, professionals noted that earlier completion of the GCP may have been beneficial as a targeted support plan could have been actioned sooner. To encourage early consideration of the GCP a new screening tool is being trialled with Tameside Families Together. The new screening is completed on every child upon allocation and serves as an indicator as to whether a GCP should be completed. This neglect screening tool[10] is within the form's tabs on the Early Help module (completed for every child) and one of the advantages of using it is that it ensures input from other agencies. This tool, if proven to be effective, will be usable at the referral stages of cases to help indicate concerns, regardless as to whether the case is to be referred to MASH or Early Help.

3.2.4 Professionals who are concerned that the new system could become too time consuming will be reassured that they should only complete the areas of the GCP that they are able to. Any outstanding areas will be tasked to the appropriate professional upon receipt of the referral. Also, it is recognised that completion of the GCP may sometimes be decided not to be appropriate and this is acceptable, but the decision-making rationale must be documented on the notes.

3.2.5 Professionals at both of the Learning Events recognised the value of the GCP and were in agreement that its profile needs re-raising to ensure that it is a multi-agency process and completed in a more timely manner, but professionals discussing Ben raised a valid concern.

3.2.6 When a GCP was completed regarding Ben and his siblings, mother scored herself far more favourably than professionals and still struggled to understand the concerns. It

[9] The GCP is an assessment tool used to assist in the assessment of neglect. The tool identifies both strengths and difficulties across a child's development areas, but focusses upon the strengths. This is to help professionals appreciate the potential within a family for improvement and change.
[10] A tool intended for practitioners within all partner agencies to help identify areas of concern which may indicate a child is being neglected.

was clear that mum's views regarding what constituted neglect differed from the views of professionals and completing the GCP did not bring them into alignment.

3.2.7 This disparity was yielded from a fundamental difference between how Ben's mother perceived her own parenting and provision of care, and how professionals observed it to be. When the children being considered are like Ben, young and/or nonverbal, this is difficult to overcome because completion of much of the GCP is unavoidably upon what a parent reports to do. For example, Ben's mother told of multiple meals that she cooked for the children. At the time the worker found little evidence of this. An older verbal child can tell a worker what they have had to eat. Younger nonverbal children cannot. Similarly the descriptors around hygiene, safety, esteem and love are somewhat dependent upon a parents reports. Other descriptors such as those regarding décor and physical care can be more easily challenged but can still be disguised or defended to some extent.

3.2.8 In addition, a study[11] completed in a local authority in Scotland has demonstrated that the language used within the GCP can be an aggravating factor that broadens disparity between practitioners and parents views. The study concluded that the language used in the GCP was proving to be an *obstacle* and that *parental understanding of the GCP had been a difficulty.* Practitioners partaking in the study clearly also had worries about the language. They contributed;

- *I think that some of the wording is very complicated for many of the parents we work with and this prevented me from doing it jointly with the parent who, in this case, has literacy issues.*
- *I found it really difficult to explain it and put it into more simple language.*
- *It has a real middle class feel to it... the language in it and some of the views about good parenting.*

3.2.9 However, in the absence of the reviewer having the opportunity to ask Ben's mother her opinion, this report cannot conclude for definite that the GCP language contributed to the resulting disparity of the scores in Ben's GCP.

3.2.10 Although the TSCP website offers comprehensive GCP guides, there is no advice for a professional who finds him/herself in a situation where the professional and parent score differs widely but significant disparity must not be ignored. Professionals must give careful consideration as to whether, where parents' principles and viewpoints have notably differed from those of professionals, they have challenged them effectively, and professionals who are unsure should discuss case progression with supervision.

3.2.11 Currently there isn't any standalone training for the GCP, but there is a half day virtual neglect course which looks at the neglect screening tool and the GCP. However, Social Care is presently producing a training package for new staff workers that will include the GCP. It was discussed at the panel meeting how, given that problems associated with staff turnover occur in most organisations, such training could be utilised within all agencies to ensure that new starters have the information to hand and aren't learning from a colleague who may not have a good enough understanding of a procedure in the first place.

3.2.12 Most agencies agreed that this would be a good way forward but education recognised that Academies do not have to accept their offer of training. Pennine

[11] Sen, R., Green Lister, P., Rigby, P. and Kendrick, A. (2014) 'Grading the Graded Care Profile' in Child Abuse Review, 23 (5) pp. 361–373. doi: 10.1002/car.2257.

Care added that they have a number of mechanisms for sharing and cascading information[12] and the GCP could be included.

3.2.13 **Lesson 2:**

Practitioners do not always understand how and when to complete the GCP effectively or recognise when to seek the advice of a manager/supervisor.

A new training package is currently being developed by Early Help, Social Care and partners and this will assist to ensure that this learning point is addressed.

Recommendation 1:

The partnership should seek assurance that the GCP training package is completed, and post roll-out, should seek to evaluate whether professionals are now understanding the tool and embedding it into their practice effectively .

3.3 Voice of the Child and Lived Experience

3.3.1 All professionals recognised the importance of the Voice of the Child and of exploring their Lived Experience in order to gain depth of understanding for assessment and case progression. However, discussions evidenced that hearing a child's true voice isn't as easy as it sounds and professionals can face barriers.

3.3.2 An immediate barrier in Alex's case was that the social worker undertaking the assessments did not have a trusted relationship with Alex and this made it harder for her to discuss her personal circumstances. And Alex has told this review that in addition to not knowing the social worker, she found it hard to relate to him because he was a man. Best practice would be to consider a case and match a worker to the child's needs, but it is recognised that staff resources may not always allow this.

3.3.3 Alex's lived experience couldn't be understood without learning about her parents' sentiments and attitudes. As such it is paramount that professionals achieve a trusting relationship with not just the child but with the whole family. Alex and her family have had much previous involvement with social care and both spoke of positive and negative relationships with previous workers. It is clear that there was much apprehension from all family members regarding another social worker becoming involved. This is understandable and social workers should never underestimate the impact they can have on a family when they come into a home and ask questions.

3.3.4 Alex's mother described feeling blamed and judged. There is no indication of this being the social worker's culpability, but it does highlight the need for a worker to be careful about the type of language they use as negative language can damage relationships. Alex's mother said that often when she spoke with social workers she felt as if she wasn't listened to and that her views were deemed as wrong. She told the review that she had been concerned about Alex displaying sexual behaviour since she was much younger, and had asked for help in the past but that no

[12] The mechanisms include: • monthly safeguarding update, presented at every Care Hub Quality Forum which forms part of the Trust Integrated Leadership Model. Any changes in practice and service provision from Tameside local authority would be included in this update and shared at the Tameside Quality Forum, CAMHS and Learning Disabilities Quality Forums. Individual service managers attend the Quality Forums and have a responsibility to cascade the information to their teams. In addition this information forms part a reporting mechanism which feeds up to the Trust Tier 1 and 2 structures. • A quarterly Safeguarding newsletter to all staff which includes any changes in practice or service provision. Whilst Trust wide this can include borough specific information. • a Trust intranet page signposts staff to Tameside Local authority and Tameside Safeguarding Children Partnership web page. • The Safeguarding Team also post on the staff noticeboard via the intranet that all staff can access and this is where the TSCP bulletins, training opportunities are cascaded.

successful work had ever been completed. As a result she had lost faith in being open about her concerns.

3.3.5 **Lesson 3:**

Staff resources did not allow for the social worker to be best matched to the child's circumstances.

The review has been assured that a recruitment drive has addressed any staff capacity issues and that allocation managers in all agencies are being reminded to best match workers to cases and to utilise any other trusted relationships a child may have with another professional.

3.3.6 Professionals' experiences with Ben were different. The barrier to hearing his voice and learning of his lived experiences was his age. This was despite an acknowledgement that much research and information is widely available to support workers in this area. Professionals spoke of still seeing the phrase '*child too young to give views'* on assessments and concluded that not enough observation of such children is being had. Indeed the phrase is present in an assessment of Ben. It is concluded with a reassurance that his wellbeing is considered holistically through play, interaction, and observation, but lacks detail.

3.3.7 Professionals have to rely upon thorough observations and the details of others when considering young, preverbal children. Any laxness generates a danger of inadequate representation of the child. Further discussion with professionals concluded that professionals sometimes muddled the child's lived experience with their voice and omitted one or the other. They agreed that no matter the age of a child, professionals must describe in their assessments the child's views and document how those views are being determined (child's voice) and accompany this with a reflection of what the child sees, hears, and experiences on a daily basis (lived experience). This is important because a child's record sits in many places including assessments, court reports, case conference and records of visits, and as Ofsted's National Director for Social Care noted in 2019[13], *a well-crafted child's record should be able to show what's happening for a child at any given time. A good record will show children's wishes and feelings and their understanding of what is happening in their life. Even though young children and those without verbal communication cannot talk about their feelings, recording observations of them is still very important.*

3.3.8 In addressing how we can achieve this and hear the voice of a preverbal child, this report will reflect upon what is known about how a preverbal young child 'remembers' their experiences and absorbs their environment. Dr Amber Elliott wrote[14], *Babies have neither the ability to talk, nor even to think in an organised enough way to think using words. Their memories are stored in a non-verbal, procedural way… sensory memories are completely different from verbal memories and stored in an entirely different part of the brain. However, they are as powerful, if not more powerful, than verbal memories.*

3.3.9 This suggests that preverbal children hold the information about their environment but are unable to communicate it verbally and this highlights the importance of infant observation in order to gain the child's views. In the absence of a voice, practitioners must describe a child's physical appearance and observe their interactions. How does the child react to a loud noise? Is the child comfortable

[13] What makes an effective case record? - Ofsted: social care and early years regulation (blog.gov.uk)
[14] Trauma Memory - The Child Psychology Service

around strangers? Does he or she look to mum for reassurance, or dad, or a sibling? Does he or she smile, present as happy? Does he or she cry? Is he or she impassive? Such observations will give some insight into the voice of the child.

3.3.10 To accompany this voice with the lived experience, practitioners must then establish what a day in that child's life is like. Ben's assessment after he was placed under the Section 20, could have been improved with a description of what he was now seeing, hearing, and experiencing, instead there is a supposition that he *appears to be content in his placement*.

3.3.11 **Lesson 4:**
Professionals are not consistently including the voice and lived experiences of young, non-verbal children in assessments.
This is discussed further later in the report.

3.4 Information Sharing with GP Surgeries

3.4.1 Information provided to the review from the GP's suggest that GP surgeries may not always be adequately included in multi-agency intervention. As health presentations were recurrent for both Alex and Ben, better sharing of information with the GPs would have been beneficial.

3.4.2 Alex presented at the GP practice many times with abdominal pain. No physical cause was identified but given that there is some evidence which identifies non-specific abdominal pain in children can be linked to sexual abuse, it would have been good practice to explore this further. At the very least the GP could have considered whether in light of the home environment, emotional distress could have been a differential diagnosis. However there is evidence that the GP was not aware of some key changes regarding the family, such as re referral to multi-agency safeguarding services and thus, would not have recognised the current concerns regarding Alex's environment.

3.4.3 Improvement to Alex's information sharing with the GP surgery was seen when Child Protection processes were initiated; the GP was made aware of the plan progression and its discharge. However, information sharing is a two-way street and the GP surgery has recognised that their information sharing can be improved as they did not routinely contribute to case conference. Consequently, other agencies may not have been aware of Alex's physical health and what the symptoms possibly indicated. The team manager of the Conference and Review team is currently working with a named GP to look at improved conference information sharing with GPs.

3.4.4 Due to a number of health problems, Ben's GP often saw him alongside other members of the family. Although his GP reports to be aware of the safeguarding concerns and considers that information was shared appropriately, the frequency of presentations could have been shared multi-agency as a possible indication that the family were further struggling and that intervention required escalation.

3.4.5 It is understood that GP's have thousands of patients and that patients will not always continually see the same doctor in their practice, but GPs are part of the universal service offer for children and young people and there is an expectation that they contribute and partake in safeguarding. High patient numbers, poor information sharing and systemic problems, such as family members not linking together cannot be addressed overnight, but GPs can be careful not to accept

anything at face value and should remember to show professional curiosity[15] during their consultations.

3.4.6 Professional discussion around the subject of GP safeguarding during the panel meetings for this review has highlighted how difficult the issue of GPs and safeguarding is. It has been identified that:

- there is little understanding of what realistic changes could be made to improve GP safeguarding, and
- other agencies have limited understanding of GP systems - as such changes cannot be made without better insight and awareness of the role.

3.4.7 **Lesson 5:**

There is not enough multi agency understanding of the GP role and responsibilities to establish what agencies can reasonably expect of their safeguarding processes.

Recommendation 2:

The Partnership should ensure that consultation is had with a number of GP's to:

- **gain a better understanding of the GP roles and responsibilities,**
- **to understand what can realistically be expected of GP's in terms of safeguarding, and**
- **to learn how other agencies can help them to achieve.**

3.5 Signs of Safety

3.5.1 In 2018 Tameside introduced the Signs of Safety model into their work. This model is a strengths-based, solution-focussed approach which works by balancing safety and risk. Professionals work in partnership with families to identify and recognise protective factors and strengths where appropriate. Scaling questions[16] assist professionals to establish the level of help and support needed and to track progress or decline, and safety tools such as 'three houses[17]' are used to monitor progress during family visits and monitoring meetings.

3.5.2 As such both professionals and non-professionals have a role to play in Signs of Safety and again, it is essential that the social worker has a good relationship with the child who is central to the case in order to be able to gain their trust to learn and understand their experiences. This is important because the professionals use what the child has said and/or depicted about their situation to help parents to reflect and make changes. Subsequently a major aspect of how agencies review support and intervention is dependent upon the relationship a child has with their workers (the importance of workers building good relations with children and families has arisen frequently during this review process).

3.5.3 The Signs of Safety model was used in both Alex's and Ben's case conferences. To clarify its approach, it has three columns which ask, 'What are we worried about?', 'What's working well?' and 'What needs to happen?' Seven domains are spread across those columns as follows:

[15] The capacity and communication skill to explore and understand rather than to make assumptions or accept things at face value.
[16] A question that asks someone to rate something on a scale of 0 to 10, where the 0 and 10 are clearly defined
[17] The Three Houses is an information gathering tool developed from the concepts of Te Whare Tapa Wha (Professor Mason Durie), resiliency theory, solution focused theory (Steve De Shazer and Insoo Kim Berg), and Signs of Safety (Andrew Turnell and Steve Edwards). It is divided into three houses which represent Vulnerabilities, Strengths, and Hopes and Dreams.

SIGNS OF SAFETY FRAMEWORK		
What are we worried about?	What's working well?	What needs to happen?
• Harm • Danger Statements • Complicating Factors	• Existing Strengths • Existing Safety	• Safety Goals • Next Steps

3.5.4 Although professionals were mostly encouraged by the models' use in case conference, concerns were raised that as time progresses the first column can cease to reflect the history of concerns and instead begin to focus on more recent worries - which are then addressed. A consequence of this is that the scaling questions, which are based upon the correlation of the danger statement to the safety goal, will elevate to a higher figure and there is a danger of eliciting a misleading overall picture. Ultimately the model becomes a rolling board and Adverse Childhood Experiences and/or historic parenting concerns can become overlooked.

3.5.5 To overcome this professionals must be confident in sharing any additional worries that are not included within the danger statements or mapping during the conference, and must remember that the final decision-making remains based upon the threshold of significant harm and is not replaced by the scaling questions.

3.5.6 Professionals also said that despite detailed training, they still felt that the Signs of Safety model, was not being completely embedded into practice. This could be attributed to the complex nature of introducing such a change into child protection practice but could also be partly owing to staff turnover. This is an idea echoed in a Signs of Safety study[18] which denotes that implementation may take a period of five years.

3.5.7 Interestingly, despite the majority of professionals who were spoken to within this review process having a mostly positive opinion of Signs of Safety, a recent government-commissioned evaluation[19] has concluded that there is *little evidence* that the model leads to better practice or reduced risks and that there is no moderate or high strength evidence of it decreasing the probability of a child being re-referred. Tameside is now conducting its own review into Signs of Safety. A piece of work is ongoing that is looking at the impact of the model and how well it is embedded. In the future, Tameside will be consulting with staff and families regarding its effectiveness.

3.5.8 **Lesson 6:**

Professionals have some concerns regarding the success of the Signs of Safety model and its use in practice.

Tameside has recognised this and is undertaking a piece of work that will help them to understand the impact and effectiveness of the model.

[18]https://assets.ctfassets.net/7swdj0fkojyi/2d9bU5LbiYQlUkiMy4MkMC/d1dd7ba5b7bc457880e3fdfed631570a/SoS_systematic_review_GD_Edit_v3.pdf

[19] Evaluation of MTM's Signs of Safety Pilots (publishing.service.gov.uk)

3.6 Covid

3.6.1 In December 2019 a coronavirus emerged which was rapidly identified as pandemic. As a result the United Kingdom saw the Prime Minister announcing a national lockdown on the 23rd March 2020.

3.6.2 Everyone worked relentlessly to maintain service and continuity but professionals and service users had to rapidly adapt to new working conditions. It is clear that over time, practices and communications within the new working conditions have become more effective and the ability of staff to adapt is admirable. But this review must look at the resulting quality of support that was afforded to both Alex and Ben and their families.

3.6.3 Professionals at both of the Learning Events discussed the pandemic associated changes to their work routines and identified the following:

3.6.4 Many workers left the office to work independently from home. Although there was safety and flexibility in doing this, staff had to quickly adapt their home living spaces to the needs of multiple family members working from home whilst simultaneously attending to their children's educational needs. This was sometimes distracting.

3.6.5 Professionals at both Learning Events spoke of the isolation of working from home and being away from colleagues. Agencies in the MASH; a team which was built upon the principle of co-locating organisations together, found themselves separated by the pandemic and working remotely. Alongside the loss of being easily able to engage with partner agencies, staff found themselves isolated from members of their own team and missed the reassurance that working alongside colleagues and supervisors brought.

3.6.6 A professional development paper published in September 2020[20] has considered the *Impact of Remote Working on Practitioners* and the decrease of support networks available. It highlights that peer support is *instrumental in managing levels of secondary trauma experienced by practitioners*[21] and that current circumstances have removed the opportunity for a practitioner to *offload* with colleagues. It also notes that *effective support and supervision from management*[22] is an important factor contributing to practitioner wellbeing and whilst it has still been provided during covid, it has been done so over the phone or through a communication platform for many. This does not compare to being present with a colleague in *a supportive environment* and the potential for *practitioner burnout* has increased.

3.6.7 Professionals had to stay in touch with each other both within their own organisations and externally with others. Virtual communication platforms such as Skype, Zoom and Microsoft Teams started to be utilised. At first, different sectors

[20] From Unnoticed to Invisible: The Impact of COVID-19 on Children and Young People Experiencing Domestic Violence and Abuse - Donagh - 2020 - Child Abuse Review - Wiley Online Library

[21] Lliffe G, Steed L. 2000. Exploring counselors' experience of working with perpetrators and survivors on domestic violence. Journal of Interpersonal Violence. 15[1]:393-412

[22] NSPCC. (2013) Vicarious Trauma: The consequences of working with abuse.

used different virtual platforms which stilted inter-agency communications and not everyone had access to computer stations or all of the equipment that they needed. Those that did weren't always familiar with the communication tools and they had to rapidly learn how to use them.

3.6.8 Many face-to-face appointments/visits with members of the community were replaced with telephone appointments. For example Family Support Workers and Health Visitors were not permitted to enter houses. Ben's Health Visitor said that as a result Ben was not seen by a Health Visitor from February 2020 to July 2020. A Health Visitor did keep in contact every two weeks by telephone but it was not until visits resumed that they realised what they had been missing; there had been 2 A&E visits in that time, he had fallen off the bed and been sprayed in the face from cleaning product.

3.6.9 Not everyone had a role where working from home was a possibility and for them the worry of contracting the disease themselves whilst going about their work was significant. Those professionals who were still permitted to enter people's home spoke of how because fewer professionals were attending the homes, it put a strain on those who could. One social worker spoke of feeling on her own, and feeling a lack of shared responsibility across the agencies which meant more pressure on those with statutory responsibility. She explained that social workers have been supplied with gloves, aprons and masks and have been allowed to still go inside homes but their home visits have remained limited as often the families have reported to be self-isolating. There has been no way for a professional to check whether self-isolation has been genuine or used as an excuse for no entry and it has been a worry that self-isolation may be being used to hide a deterioration in home conditions or to avoid social worker contact. Ben's social worker reported that even when entry had been gained to the home, barriers remained as she hadn't been able to hold him and she had to keep a distance from the family members. Masks, she explained, had been a massive barrier to communication with children, especially with non-verbal children like Ben who respond to faces and smiles.

3.6.10 The family intervention worker continued to visit Ben and between the 24th March and the 4th May 2020, completed six home visits. However, the visits were doorstep visits and the two-metre rule was adhered to. Consequently home conditions were only seen through the windows downstairs and Ben could not be held. Practical support was still offered by means of shopping for the family (Ben's mother advised that she was not leaving the house with her children) and verbal support was offered in relation to managing the children's behaviour. Ben's mother was also offered one to one telephone support from the parenting support team.

3.6.11 From 13th May to the 14th July 2020, sessions were held inside the home address with the two-metre rule staying in place. This was better because home conditions could now be seen throughout the house, and the cupboards and fridge and freezer could be checked to ensure that enough food was available.

3.6.12 Covid had a significant impact on the Child Protection Conferences. The Conference and Review Team worked hard to get virtual conferences up and running but as one chair said in a Learning Event, '*conferences are all about working with people so it has not been ideal*'. Professionals suspected that some families would have found the virtual approach impersonal and difficult but because no professionals were in the room with the families during the meeting it wasn't easy to tell if an attendee was becoming distressed or distracted. There was

also a worry that families could have had other people present in their homes who may have overheard confidential information or that children may have witnessed parts of a conference not suitable for them.

3.6.13 The conference chairs spoke of Signs of Safety being a visual aid and some of its strength being lost in a virtual environment. Similarly, sitting down with parents before a conference has been missed as you can learn a lot about the family in this time and it helps a chair plan how to manage the direction of the conferences. The conference chair overseeing Alex's plan spoke of how this was improving because they were now allowed now to have parents sitting with the chair, social worker, and minute taker during the meeting. This review was told that this is much better but because the numbers are limited to 5, parents are still missing the chance to bring a support person with them.

3.6.14 Virtual conferences have also resulted in agency reports not being shared prior to the meeting. This is because of concerns around confidentiality and the difficulties in maintaining control of reports in a virtual arena. Consequently there is a worry that some information may be overlooked and not shared effectively.

3.6.15 In addition to the conferences, core groups and strategy meetings became virtual. Some agencies including the police have identified that virtual strategy meetings worked well as they turned out to be more timely and as a result more agencies were able to attend and more information was shared.

3.6.16 Staff absences were a factor for all agencies as workers who had been exposed to the virus had to self-isolate and those unfortunate enough to contract Covid were off work. Practitioners were sometimes redeployed to other teams to give additional support elsewhere and many teams were left with skeletal staff. The police said that this, alongside members of the public postponing voluntary interviews for covid related reasons, had definitely been a factor within their work and had slowed the investigation into Ben's injuries.

3.6.17 Hospital practitioners noted that besides hospitals being heavily affected by staff shortages and having an increased reliance upon agency staff, there was an increased number of attendances during covid because people didn't have easy access to their GP and so used the urgent treatment centre instead.

3.6.18 Both Ben and Alex were offered the chance to continue their education at school/nursery during the pandemic but neither family took advantage of this. This has effected both children falling further 'out of sight'.

3.6.19 Consequently the main issue for both Ben and Alex during the pandemic has been their heightened vulnerability caused by this reduced contact that they have had with professionals. This has resulted in a lesser chance of any issues being detected.

3.6.20 Overall, professionals have been aware of this risk and have worked hard to minimise it. Those who have been able to attend the home have, others have maintained telephone contact and school and nursery have kept their doors open for them.

3.6.21 However, there is a concern that this heightened vulnerability may have been overlooked when Ben was discharged from the Child Protection plan in July 2020. The minutes from the meeting reflect that practitioners reported this review period (February to July 2020) to be a positive one but the information provided to the

review was unavoidably vague due to covid; only the social worker and the Family Intervention Worker had been to the home address. The education report noted *no concerns* but Ben hadn't been attending nursery regularly and on an occasion in June, nursery had reported marks on his bottom to Children's Social Care. The Health Visitor had only had telephone contact and housing had closed their case as the safeguarding concerns were being addressed by Children's Social Care.

3.6.22 Although improvements were evident during this review period, it should be noted that Ben had suffered a fall, and been sprayed in the face with a cleaning product. Both of these incidents indicate a lack of parental supervision. Also, Ben's mother was allowing a male into her house (he was witnessed to be decorating the address within a week of the plan being discharged) and it is not clear to this review whether he had been considered. It is also not clear whether any consideration was given to how much the pandemic was tainting the overall picture, for example, Ben not attending nursery was 'excused' as was lack of engagement with any service - isolating offered a legitimate excuse and consequently assisted any disguised compliance. And, any gatherings of people at the home address would have to have been kept low-key and out of sight and could have gone unnoticed.

4 Family Information

4.1 The contribution to this review made by Alex and her mother have been invaluable in helping the review to understand how social work feels for the child and family. Some of their views are woven into the body of this report. Additional information is reported here:

4.2 Alex's mother has repeatedly expressed confusion about the safeguarding processes being undertaken around her family. She has demonstrated bewilderment regarding meetings and their objectives. She doesn't understand the Signs of Safety methodology and feels that she completes work and tasks without reward or recognition within the scales. It is fair to say that Alex's mother has shown signs of considerable distress and fear regarding the Public Law Outline that she now finds her family within.

4.3 The review must ask whether consideration is being given as how hard it must be for Alex and her family to engage with a process that they barely understand and are in fear of. Although professionals have repeatedly explained the processes to Alex'S family, it is not acceptable that a parent doesn't understand processes involving their children and continual effort must be made to find a way to help them.

5 Responses to the ToR

Having reflected upon thematic discussions, this section of the report will reply to the ToR individually.

5.1 How effective is the strategy meeting process and its alignment to Working Together 2018.

5.1.1 Although this review has found that the strategy meeting process is mostly effective and in line with Working Together, there are examples within both of the two cases explored of failures to convene when it would have been appropriate. Some of the missed opportunities have already been highlighted in this report but there is a further example

dating from when Alex was involved in peer abuse in 2019, which suggests that the strategy omissions are not isolated examples.

5.1.2 It is recognised that the strategy meeting after the sexual assault disclosure regarding Alex in 2020, could arguably be labelled as 'delayed' as opposed to 'missed' but its timeliness effected a poor multi-agency immediate response to the situation. Careful planning and early and decisive action will reduce the risk of long term harm to the child; *The longer a child is left inadequately protected from abuse and neglect, the greater the chance that their long-term well-being will be compromised* [23]

5.1.3 Analysis of previous case reviews finds that strategy meetings not convening is a recurring concern. As part of Learning into Practice[24], SCIE[25] have analysed such reports in an attempt to support managers and practitioners tackle the issue and found two reasons for not convening:

- Agencies have held internal meetings about a case. *(This has excluded other professionals from other organisations who haven't been involved.)*
- Several competing meetings have been held. *(This has impeded collaborative decision-making.)*

5.1.4 Both of these reasons pertain to this review; school, social care and police all held their own internal meetings/discussions regarding the case of Alex and none of the meetings, nor the Child in Need meeting identified the need for ICPC like the subsequent strategy meeting did.

5.1.5 Further information gathered by SCIE from three multi-agency summits, highlighted additional underlying reasons and the review will now look at each in turn in relation to these two cases.

- A misunderstanding of purpose and status
  This was deemed to be the case by practitioners at Alex's Learning Event who thought that there may have been some misconception that proof of harm was needed before convening a strategy meeting. Hence the decision to speak to Alex about the circumstances first. Better practice may have been to use a strategy meeting to decide how to gather the information from Alex as all of the information is not needed prior to convening.

- A lack of police capacity to attend
  Although the SCIE research uncovered police capacity to be a problem, police capacity was not identified to be a problem in this review. However professionals at the Learning Events reported that changes made within Children's Social Care, which merged the Duty and Assessment Team with the long term safeguarding team, resulted in an initial staff decrease which did temporarily affect their capacity. This was quickly addressed with a recruitment drive and practitioners agreed that overall, in contrast to the findings of this research, Tameside is not always at full capacity regarding strategy meetings.

- A reliance on medical opinion, despite lack of attendance at meetings
  Rather than a reliance upon medical opinion being a reason not to convene in the cases subject to this review, a strategy meeting did not convene when Ben was discharged from hospital because he was known to be going to a place of

[23] Davies and Ward, 2012; Brown and Ward, 2013
[24] A one-year DfE-funded project conducted by the NSPCC and SCIE.
[25] Social Care Institute for Excellence

safety under the Section 20 agreement. However, the lack of such a strategy meeting, which the hospital staff would have attended, will have resulted in social worker's or police interpreting medical information from the hospital themselves. This could dangerously lead to a misinterpretation of medical matters and subsequent confusion. A strategy meeting would have provided professionals the opportunity to ask questions re the medical opinion so that they fully understood and did not rely upon their own or another non-health professional's interpretation.

- The thresholds and capacity to respond
  Thresholds were discussed in both meetings with multi-agency unanimous conclusions, but there is an issue that thresholds may be interpreted differently in a single-agency environment. Single agency consideration may result in a decision not to request a strategy meeting where another agency may have concluded one necessary. There is always a risk of agencies having differing views as to when intervention may be necessary.

- The format of meetings
  The covid pandemic temporarily halted face-to-face meetings, but as mentioned, some professionals considered the virtual strategy meetings to be better. More professionals were able to attend when time to commute did not have to be taken into consideration and this has improved the amount of information being shared multi-agency. Keeping some strategy meetings in a virtual format may support agencies to convene and attend.

- Professional Challenge
  Professionals at Alex's Learning Event questioned whether agencies, in particular education, sometimes deferred to the experience of others, regarding the decision-making process behind the strategy meetings. As a result, those with the most knowledge of the child didn't get the opportunity to share their information at the start of intervention, or challenge the decisions of others on case progression.

5.1.6 **Lesson 7:**
Strategy meetings are not consistently held in accordance with Working Together and agencies do not always convene and attend as per guidance.
As per page 6, GMP has shared training with other agencies for dissemination.

Recommendation 3:
A multi-agency audit via the Partnership should consider dip sampling records of strategy meetings and analyse the results to develop an effective training session that will address any inconsistencies and weaknesses in the strategy meeting process.

5.2 **What is practitioners' understanding of historical and multi-agency evidence and the application of thresholds based on their recognition and response to risk (Neglect & Sexual Abuse)**

5.2.1 Tameside maintains Threshold[26] Guidance to support professionals with their decision-making. It explains for all agencies and sectors, *the varying levels of need and the associated thresholds, indicating when a child, young person or family might need*

[26] A 'Threshold' is the point where such a level is reached that professionals determine that the criteria are met for statutory intervention in family life, or a child should receive a specific type of support.

support. In theory the guidance should result in a consistent application of thresholds. But in practice, it is dependent upon an individual's judgement and decision-making and their interpretation of significant harm. Subsequently there is always a possibility of risk factors transmuting an uneven response.

5.2.2 In an attempt to reduce this risk, there are four levels of descriptors of need. Each level model helpfully describes the criteria professionals must determine when considering what assessments and support children and their families require.

5.2.3 With regards to Alex, professionals in the Learning Event discussed her circumstances and considered:

- the sexual assaults,
- agencies historic intervention and
- the known dynamics in the family home,

They came to a unanimous conclusion that she met high thresholds. Yet, at the time, no strategy meeting convened and the need for ICPC was not initially considered. The unity of the discussions in the Learning Event suggest that rather than professionals having an inadequate understanding of thresholds and/or significant variants upon the application of harm, poor information sharing, and assessments not being undertaken and shared soon enough, affected their recognition of risk.

5.2.4 In the absence of a multi-agency strategy meeting to share information, when professionals' attention was brought to the photograph on social media of Alex, practitioners initially focused upon the sexual incident and lost sight of the historic information that was known to them[27]. This is understandable as the threshold for sexual abuse is definite in that any sexual activity with a child is abuse. But all of the risks to Alex needed to be considered and understood in the first instance in order to identify any underlying drivers to her vulnerability and ensure that the correct support was offered.

5.2.5 A good understanding of thresholds was also echoed by professionals considering Benand discussions of his case demonstrated good information sharing amongst agencies. However, it was agreed that historic information such as long-standing neglect, had sometimes been overlooked in assessments[28] and that in time as work with Ben and his family progressed, less weight was given to history. This was because when assessing the current risk professionals focused on the Signs of Safety scales which reflected the more recent concerns. As discussed earlier in the report.

5.3 **Do assessments of children in families where there is domestic abuse and neglect, fully include the voice of the child and do they explore their daily lived experience.**

And,

Did partner agencies review the impact of the support and intervention to allow them to understand and make a difference to the daily lived experience of the child.

(These two ToRs are considered jointly as the analysis is correlated.)

5.3.1 Professionals demonstrated a clear understanding of the importance of reflecting a child's views in their assessments and case management. But as discussed previously, were frustrated by barriers which hinder the process, in particular when the child is young and preverbal like Ben.

5.3.2 Alex's social worker offered her many opportunities to describe things from her point of view and as a result her voice was evidenced in assessments. But in the absence of a

[27] Neglect was not an immediate consideration until it was presently identified during the child and family assessment.
[28] The CAF assessment process changed in 2019 and the background is now considered more carefully.

trusted relationship between the social worker and Alex any voice reflected in assessments was controlled and somewhat superficial. For example, she says her relationship with her mum and step-dad is good but there is no further exploration of what 'good' means. What does she do with them? Does 'good' mean that they leave her alone, or does 'good' mean that she talks to them about her day, her worries, her feelings.

5.3.3 It has already been documented that the social worker's gender was an immediate barrier and consequently Alex's general distrust meant that he had to break through her walls of wariness before she would start to open up. This added an additional obstacle into a process which is already difficult in any circumstances, as both domestic abuse and neglect are difficult for most children to talk about. And Alex, like many children, is loyal to her mother so would be automatically guarded.

5.3.4 Given these barriers that the social worker was already facing, there is little surprise that the assessment does not offer much reflection of her lived experience other than that she visits her nana and watches films. Time for a social worker to develop a more trusted relationship would perhaps solve the problem of helping a child to reflect honestly upon his or her feelings and environment, but that is a luxury that assessments cannot afford as their speediness is necessary. Perhaps more creativity is required within the questions posed to help elicit information to assess neglect and/or domestic abuse. More questions about family routines, what is it like to live in this house – is it a quiet house, where's your favourite place to go in the house and why? What do you like about going to Nanas? Etc.

5.3.5 *'Learning to ask questions that open up possibilities is an art form that takes practice'*[29] and something that is developed with experience. Experienced practitioners should share their knowledge with newer workers and help them to learn where and how to best place questions into a conversation.

5.3.6 In addition a publication[30] in the journal *Relational Social Work* has suggested that *if we want to engage and communicate effectively with young people we need to continue to pursue different methods for example phone, text or through the internet via email, face time or Skype. Young people may find that indirect or non-threatening ways of communication are much easier than direct communication for relationship building. There is huge value in face- to- face work, however, practitioners in terms of building relationships need to blend their communication approach with young people.*

5.3.7 It is good practice that school were asked to contribute to the assessment. The assessment was completed during the covid pandemic when Alex was not attending, but it would have benefited from more information. When Alex attends school, who brings her and picks her up? Is she usually on time or late? How does she present? How is she at lunchtimes?

5.3.8 The assessments evidence that the social worker talked and listened to Alex, and that Ben's social worker observed him with his mum, but the quality of the information could be improved upon. This is not a criticism of the individual social workers; their workloads are high and they are working under immense pressures, but the efficiency of assessment is dependent upon the interactions between the workers and the children. Social workers

[29] Graybeal C (2001) Strengths-based social work assessment: Transforming the dominant paradigm' Families in Society, Volume 82, Number 3, pp233-42, (p241)
[30] Relational Social Work Erickson Vol. 2, n. 2, October 2018 (pp. 50-60) doi: 10.14605/RSW221805

should let children know that they understand why they don't trust them and promise to work to earn their trust. There needs to be more importance on spending time with children to develop positive relationships as an intervention intrinsically. As such social worker's time with the children they are assessing must be protected.

5.3.9 Understanding and recording the daily lived experience of the child should be done by all professionals working around a child and it is not just crucial during assessment. When professionals at the Learning Events were asked to describe how they monitored the support and intervention offered to a child, they detailed regular reviews with supervision and management, and the use of the Signs of Safety tool. Although these processes are part of the monitoring package it was concerning that no one mentioned ongoing analysis of the child's lived experience and/or voice.

5.3.10 True case management and progress can only be made by obtaining a child's lived experience and tracking the changes. Every visit with the child is a contribution to the whole assessment and every visit record should reflect the current lived experience and the child's understanding of his or her environment. This is crucial to keep the child visible and the plan child centred.

5.3.11 Sadly despite committed professionals and previous interventions, the care and safety of Alex and Ben has continued to fluctuate and resulted in re referrals to services. Re referrals can be expensive to local authorities, and more significantly traumatic for the children and families involved and therefore work must be done to reduce them.

5.3.12 **Lesson 8:**
Professionals are not consistently hearing a child's voice and learning of their lived experiences to assess needs and/or manage progress.

Recommendation 4:
TSCP should seek assurance from partner agencies that staff are being reminded to fully explore the lived experience of a child and to include their findings in all records including assessments, alongside the voice of the child. A multi-agency audit via the Partnership should consider dip sampling records and assessments to identify and share best practice.

5.4 **Are partner agencies working together to deliver coordinated support and interventions.**

5.4.1 There is no doubt that professionals working around both of the children subject to this review are competent, diligent practitioners but there is a concern that at times they have not coordinated their work with one another. There is evidence of multi-agency meetings and information sharing but there is also evidence of agencies not having all of the information owing to poor communication, for example, the police being unaware of the second sexual assault disclosed by Alex.

5.4.2 Discussion with the professionals working to support Alex identified a significant decision that reflected poor agency coordination when, in 2019, Alex was known to request that two of her peers touch each other intimately. The victims did not support any prosecution but the matter was referred to Children's Social Care. Although a telephone conversation took place between police and Children's Social Care, no strategy meeting convened. Consequently no multi-agency actions were documented in relation to the pathway for sexual harmful behaviours.

5.4.3 This uncoordinated approach to harmful sexual behaviours is not uncommon. The NSPCC Harmful sexual behaviour framework[31] has identified that *despite increasing evidence on the scale, nature and complexity of the problem, service provision across the UK remains patchy and relatively uncoordinated, with some beacons of good practice*. The framework aims to support local work with children and young people who have displayed harmful sexual behaviours *by delivering and developing clear policies and procedures, and by refreshing local practice guidelines and assessment tools.*

5.4.4 To coordinate their approach to sexual behaviours in children Tameside has recently produced guidance for professionals; Recognising and Responding to Sexualised Behaviour in Children and Young People. This guidance is to support professionals to recognise inappropriate behaviour at the earliest opportunity and respond accordingly. If a child has committed a sexual assault or engaged in sexually harmful behaviour then the accepted model for Tameside to follow is the Assessment, Intervention and Moving on (AIM) framework.

5.4.5 The AIM framework was initially developed in Greater Manchester in 2000 but as evidenced by the aforementioned omission of a strategy meeting, was not accurately followed to respond to Alex in May 2019[32]. However Children's Social Care did make enquiries in regards to the Barnardos support course to support Alex. This work is specialised and described as excellent but it is costly and could not be afforded. This was discussed at the Learning Event and it transpired that school were unaware at the time that this was being considered but may have been able to contribute to the funding. A multi-agency coordinated consideration of what specialised intervention was available for Alex may have resulted in multi-agency funding.

5.4.6 Professionals must remember to consider the possibility of multi-agency funding and discuss prospective cases with their supervisors to discuss with Heads of Service.

5.4.7 A further example of support that lacked coordination was discussed regarding when the photograph on social media came to light in December 2020. School advised parents to inform the police of the incident, and they completed a referral to Children's Social Care which included the further disclosure of sexual abuse. Unfortunately, from herein on, agencies initially appear to have started to work in silos. Children's Social Care began their assessment of the family and the police began their investigations into the social media picture. The police were not informed of the second disclosure of rape until the 26th January 2021 when, during a communication between social care and a police officer, it become apparent that the police had not been informed. A strategy meeting was then requested as a matter of urgency and at this point a more coordinated approach to Alex's interventions began.

5.4.8 School continued to support Alex with learning mentors and nurture groups but a recent Ofsted report[33] has identified that schools must develop and implement 'whole-school policies' to take swift, visible and appropriate action against sexual harassment, sexist and sexual bullying and sexual assault. Attention was drawn to the issue of sexual abuse in schools in March 2021 when thousands of people posted about their experiences of assault and harassment in education settings on the Everyone's Invited website. As a result of the disclosures, police forces across the country initiated investigations and ministers commissioned Ofsted to undertake a review of the current situation in schools. Although the findings of the Ofsted review, published in June 2021 called for a 'whole-

[31] Hackett, S, Branigan, P and Holmes, D (2019). Harmful sexual behaviour framework: an evidence-informed operational framework for children and young people displaying harmful sexual behaviours, second edition, London, NSPCC.

[32] Flowchart - Pathway for Response to Harmful Sexual Behaviour (proceduresonline.com)

[33] Review of sexual abuse in schools and colleges, Ofsted, June 2021

school approach', the business development manager of Brook rightly highlights[34] that we must remember that it is not just schools who have a responsibility in ensuring young people learn about consent. A 'whole-society approach' to the issue is needed and this includes youth workers, social care workers, early years, and childcare workers, as well as parents.

5.4.9 Such a coordinated approach only began for Alex when a family intervention worker was assigned. She offered Alex innovative methods to communicate her feelings and is building a trusted relationship with her. Given that at this time, Alex was leaving her most trusted relationships behind at junior school as she transitioned to secondary education, this relationship with the family intervention worker was pivotal and is a good example of work being undertaken at Alex's pace, which is crucial for a child with such complex circumstances. As the family intervention worker furthers her understanding of Alex's needs she will signpost services and support to Alex, in line with a 'whole-society approach', and will update the other professionals in meetings. This type of intervention helps to support and coordinate work around a child because although the lead professional when a child is subject to Child Protection will always be the social worker, it means that one particular worker has oversight of a child's progress and is able to hear the child's voice and update other professionals as appropriate.

5.4.10 There is no dispute that this progression of support and intervention for Alex and her family began with an uncoordinated approach, but post strategy meeting it subsequently united under Child in Need and Child Protection processes. This was also reflected in the case of Ben and suggests that Child in Need and Child Protection are successful in offering a tighter, coordinated support package to children and their families.

5.4.11 However, professionals highlighted that when a child is subject to Child in Need or Child Protection, it is sometimes difficult to share important information with other agencies if the information is not appropriate to be shared in the presence of family. And not sharing such information has a detrimental effect upon the coordinated approach. Although it is recognised that parents should be party to as much information as possible when services are involved with their families, it is non-disputable that there is some information that cannot be shared. Professionals broached that because parents attend Child in Need meetings and core groups, they are unable to share this confidential information easily.

5.4.12 Paragraph 24 of Working Together 2018 reminds practitioners to be *proactive in sharing information as early as possible* even when a child is already known to Children's Social Care. Any professional unsure of information-sharing protocol should consult the guidance[35].

5.4.13 Professionals also discussed how a coordinated approach is dependent upon any professional who is concerned about the workings of a case[36] or a decision made by another professional, feeling able to seek to address this. A professional difference of opinion does not have to reach a high level of dispute before it can be taken to a team manager or a safeguarding nurse. As a result of raising an issue, an additional professionals meeting may convene to discuss the best way to solve the disagreement before it escalates and affects the support afforded to the child.

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[34] Getting sexual health and relationships education right | CYP Now

[35] Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

[36] For example, delays to multi-agency meetings, lack of professional curiosity, incomplete assessments, struggles in communicating with key professionals.

5.4.14 Similarly, where a child is subject to Child Protection, professionals must remember to utilise the conference chair and seek his or her advice, for example, where a plan is drifting or results are proving slow.

5.4.15 If concerns about differences of professionals opinion are not addressed in one of the aforementioned ways, and/or information is not shared multi-agency, the support afforded to a child may become unevenly led and could lack an important intervention available from another agency.

5.5 **Consider the multi-agency involvement (from all relevant partner agencies) in the step down process from child protection to child in need, and closure. Are the multi-agency plans that are being put in place, continuing to mitigate and manage risk.**

5.5.1 The decision to step Child Protection down to Child in Need must be a multi-agency decision made with new consideration of the threshold to judge when the plan is no longer required; the threshold for Child Protection being an agreement that a *child is at continuing risk of significant harm*[37].

5.5.2 When a plan is no longer required, support should continue with a multi-agency plan to mitigate risk prior to full closure. But if a case is stepped down too early, this multi-agency plan is more likely to prove ineffective. Consequently stepping down is a significant decision that should be taken with caution.

5.5.3 Both Alex and Ben had been subject to Child Protection prior to the incidents that led to the commission of this review. Both had been stepped down meaning that support had previously transitioned from being managed at statutory Child Protection level 4 of the thresholds to being managed at Child in Need level 3. Alex had been through this process on two previous occasions but had repeatedly retrogressed back to Child Protection suggesting that either intervention was not proving effective in the long term or was withdrawn too soon.

5.5.4 In 2019 Salford Safeguarding and Quality Assurance Unit introduced a pre-reflective discussion for professionals who are attending initial conferences where children have returned to an ICPC within 12 months of the previous plan ending, and for children being discussed at an initial conference for a third or subsequent time. This is irrespective of the time lapse and whether they are made subject to a plan or not. Salford view this as a successful piece of work and have coupled it with further work that considers how to ensure that the correct support and contingency plans are being put in place prior to stepping down a Child Protection plan.

5.5.5 **Lesson 9:**
A number of children are being re-referred to ICPC and attempts must be made to understand and address why.

Recommendation 5:
TSCP should contact the service manager at Salford Safeguarding Unit to discuss their Child Protection re-referral and step down processes and consider adopting the same or similar procedures.

[37] The test is that either: The child can be shown to have suffered ill-treatment or impairment of health or development as a result of neglect or physical, emotional or sexual abuse, and practitioner judgement is that further ill-treatment or impairment is likely; or
A practitioner judgement, substantiated by the findings of enquiries in this individual case or by research evidence, predicts that the child is likely to suffer ill-treatment of the impairment of health and development as a result of neglect or physical, emotional or sexual abuse

5.5.6 Professionals wondered whether there had been an element of parental disguised compliance when the previous plans had been stepped down. They recognised the likelihood of this as parents seemed to find the level of intervention that the Child Protection brought uncomfortable and likely wanted it to end. It is understandable therefore that they may have consciously or unconsciously employed a disguised compliance in an attempt to leave the remit of Child Protection behind. However this is always difficult to evidence.

5.5.7 Rather than try to identify disguised compliance, better practice would be to address why a parent might disguise compliance in the first place. Discussions between the reviewer and Alex and her mother indicate that both perceived the plan as an intrusion into their lives rather than a source of support. Lots of parents and children likely have a similar view - addressing this and changing how members of our communities interpret the Child Protection arena may be the most effective measure to improve the long term effect of plans.

5.5.8 Attempts are currently made to help children and their families understand that the plan is working towards improving their situations. Currently Tameside send a letter to parents to help them to understand the process, and the chair of the conference speaks with them (and with the child if appropriate) in person prior to the meeting. In line with good practice, the chair of Alex's conference spoke with her and told her that everyone in the meeting believed her and wanted to make her life better for her.

5.5.9 In addition to the chair, Alex's social worker routinely talked to the family about the Child Protection procedure and process but the family saw the social worker as being the person who had brought them to ICPC in the first place and consequently he was not the best placed person to put their minds at rest. Even the most positive relationships already established between a social worker and a family may weaken as a result of ICPC.

5.5.10 Could the introduction of parent advocates help and subsequently improve the outcomes? Parent advocacy is where parents with experience of the safeguarding processes support other parents. This could help families see the successes of Child Protection and encourage them to own their plans and work to improve their situation.

5.5.11 **Lesson 10:**
Some families consider child protection plans to be intrusive and not a source of support. This reduces their level of true engagement.

Recommendation 6:
TCSP and partner agencies should consider developing a parent advocate scheme to support families coming to conference.

5.5.12 In the event of a Child Protection plan being discharged a multi-agency plan is conceived and notification is sent to the agencies' representatives who had been invited to the initial conference. This is good practice and necessary to keep the information that professional organisations hold about their service users/clients/patients up to date and true. But the effect of removing flags from systems was discussed at the Learning Event held to consider Alex. The GP service noted that although some historical information will remain on the system, the flag removal could be interpreted as the family no longer being under the auspice of Child Protection because they are no longer at risk of harm. Given that the GP service has not routinely shared information for Alex's case conference and has not been included in key decision-making regarding stepping down to Child in Need, a GP would have a limited understanding of the areas of concern

around Alex and this, alongside the flag removal, could explain why her abdominal problems were not considered more widely.

5.5.13 Similarly, the police remove their marker and although the information will stay on the systems, officers attending an incident involving the family may not be immediately aware of the past concerns.

5.5.14 Subsequent conversations about this with panel members concluded that due to data protection and the practicalities of continually updating partner agencies of individual risks, little could be done to change this but all agreed that the removal of a flag must not be construed as a removal of risk.

5.6 **Consider the implications to practice of the Domestic Abuse Bill that will recognise children as direct victims of domestic abuse.**

5.6.1 Both Alex and Ben have witnessed domestic abuse incidents.

5.6.2 Ben's mother has reported that her relationship with Ben's father was abusive. Due to Ben's age professionals are unable to explore with him what he has experienced and are reliant upon his mother to inform them of his presence and whether he has ever been caught in any crossfire.

5.6.3 Following domestic incidents between them in 2019 a referral was made to Bridges[38] and they offered Ben's mother support. Bridges kept in regular contact, supported her throughout the court process and addressed her concerns about the safety of the home. The Bridges worker confirmed that she was aware of the concerns around Ben and his siblings but that the focus of the work was on mum and Ben was only seen at the address on one occasion.

5.6.4 During this time, In July 2019, mother's ex-partner breached his bail conditions. This was dealt with appropriately by the police but the incident was not referred to partners despite the children being subject to Child Protection Plans. The police marker indicating the Child Protection Plan should have triggered a notification but, possibly as a result of a change in the IT system, it did not. As the police do not routinely attend core groups, police did not share their details of this incident until the next conference review.

5.6.5 Ben's father was found 'not guilty' at court and Ben's mother soon reported to professionals that he had approached her immediately after court and on another occasion had stood outside her property staring in. This clearly indicates that his abusive behaviours were continuing. Ben's mother told housing that she did not wish to report further incidents to the police. She had gone through the court process and lost faith. Clearly, intervention hadn't succeeded in stopping the behaviour nor had it given Ben's mother the tools to address it. This was a concern to professionals as it demonstrated that she felt powerless and would struggle to respond to any future incident in Ben's best interest.

5.6.6 Alex had both witnessed domestic violence abuse towards her mother and been victim of it herself from her step-father. School supported her and she was referred to the

[38] Bridges is the domestic abuse service within Tameside run by Jigsaw Homes

Children's Independent Domestic Abuse Advocate[39] (CHIDVA) in 2019 but wasn't accepted as she did not meet the criteria.

5.6.7 In December 2019 the Government was elected with a manifesto commitment to '*support all victims of domestic abuse and pass the Domestic Abuse Bill'* originally introduced in the last Parliament. The Act received Royal Assent and came into force on the 29th April 2021. Its aim is twofold. First, to create and increase awareness and understanding of the concept of domestic abuse and second, to provide additional protection to victims of domestic abuse.

5.6.8 In order to consider the implications to practice of the new Domestic Abuse Bill in situations similar to Alex and Ben, this review will first consider the parts of the Bill that will affect children.

5.6.9 The Act defines domestic abuse as occurring where the victim and perpetrator are aged over 16. Abusive behaviour directed at a person under 16 will continue to be dealt with as child abuse rather than domestic abuse. However, for the first time, a child who sees or hears, or experiences the effects of, domestic abuse and is related to the person being abused or the perpetrator, is also to be regarded as a victim of domestic abuse in their own right. This will help to ensure that locally-commissioned services consider and address the needs of children affected by domestic abuse.

5.6.10 In addition the Bill places a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other forms of safe accommodation. And the Bill gives all eligible homeless victims of domestic abuse, aged 16 and above, "priority need" for homelessness assistance.

5.6.11 More indirectly but still worthy of acknowledgement is the changes the Act will bring to the coercive control offence. A significance of this lies within the context of economic abuse which often affects children's lives following parental separation as it can present a major financial challenges to the victim parent attempting to rebuild their life and provide for the child. The Domestic Abuse Commissioner has reported that figures show that one in four women report economic abuse post-separation, and economic abuse can continue for many years after the relationship has ended. The Act will help with this as it has extended the offence of coercive and controlling behaviour so that it is no longer a requirement for abusers and victims to still be in a relationship or still live together.

5.6.12 The Bill also increases protection for families affected by domestic abuse by introducing the Domestic Abuse Protection Orders. These are intended to consolidate the existing protection orders relating to domestic abuse and allow courts to implement both prohibitions and positive requirements on perpetrators of abuse, as well as a monitoring requirement to ensure that they comply with the order's terms. Third parties will be able to apply for a Domestic Abuse Protection Order directly to the Family Court which means that professionals may apply on behalf of the people they are working with.

5.6.13 Had this Act had been in place when Ben's mother was disclosing abusive behaviours from Ben's father, consideration could have been had by professionals of applying for a Domestic Abuse Protection Order to protect and support Ben and his mother. The government has pledged to produce detailed statutory guidance and a programme

[39] CHIDVAs are independent domestic abuse advocates who work with 6 – 17 year olds impacted by domestic abuse either in the family home or their own relationships.

of training and toolkits for professionals to embed understanding of the new orders and support professionals to make such applications in the future.

5.6.14 Under the new Act, both Alex and Ben are victims of domestic abuse because they have witnessed incidents and/or the effects of. This, alongside all of the changes that the Act has introduced is welcomed because it places a duty on local authorities to support the children as victims. But the Acts success will depend upon professional's understanding of it, and the specialist support available to help children recover from what they have experienced.

5.6.15 In recognition of this, Tameside has reviewed its Domestic Abuse Strategy[40] and is in the process of:

- Procuring a 'Safe Accommodation Team' delivered by Bridges which will provide support to adults and children experiencing domestic abuse under the new duty, and those being supported will either have Sanctuary[41] in their homes or be offered temporary accommodation.
- Investing in the development of two dedicated dashboards regarding domestic abuse. The project is currently out to tender for an external data consultant to develop. The aim is that Tameside will have all of the outcomes relating to domestic abuse across criminal justice, health, housing, commissioned/specialist services and children's services, in one place. One dashboard will focus on outcomes for adults and one will focus on outcomes for children. This is in recognition of the importance of scrutinising outcomes for children as victims of domestic abuse in their own right.
- Currently there is no consistent data on perpetrators of abuse – consequently a 'needs assessment' is being developed and is ongoing to address this omission. The assessment will look at, amongst other things, demographic information, criminal justice outcomes, civil outcomes, trends and professional practice. In addition it will consult with victims and perpetrators and gather views on how perpetrators are managed in the area.
- Piloting a 12 month programme; Children that harm[42], which will pilot interventions for:
  a) children that use violence against their parent/carer and
  b) children that use violence against their sibling or intimate partner.
  8-10 counselling sessions will be provided alongside the intervention for both the child and any other children/young people that have been impacted by the behaviour
- Delivering a training programme to Social Care staff on how to work with perpetrators of domestic abuse (delivered by SafeLives[43] and Respect[44])
- Trialling a new range of target hardening equipment to keep victims safe at home and hold perpetrators more accountable. This development is still in the procurement and governance phase.
- Piloting an Independent Domestic Abuse Advocate from Bridges being based in A&E.

5.6.16 But all of this support is dependent upon the abuse being brought to the attention of professionals in the first place. The public need to be made aware that children

[40] Tameside Domestic Abuse Strategy
[41] A Sanctuary Scheme is a multi-agency victim centred initiative which aims to enable households at risk of violence to remain safely in their own homes by installing a 'Sanctuary' in the home and through the provision of support to the household.
[42] Starting in January 2022
[43] UK-wide charity dedicated to ending domestic abuse
[44] Domestic abuse organisation developing safe, effective work with perpetrators, male victims and young people who use violence.

witnessing domestic abuse are now recognised as victims in their own right, and need to understand what they can do if they suspect a child is victim. To do this Tameside is developing a domestic abuse champions scheme which will raise awareness around domestic abuse, the new act and the new definitions. The plan is to have domestic abuse champions not only within professional agencies, but also within the wider community by utilising local people who work with the public, such as hairdressers and barbers, publicans, staff within community organisations and local elected leaders.

5.7 **Review the hospital discharge process and the information that is shared with partners agencies who are providing support to that family.**

5.7.1 Ben was admitted to hospital on 21.9.20 following his mum presenting him at A&E and reporting that his penis was swollen and bruised and that his nappy had not been wet that morning. He was seen by an Advanced Paediatric Nurse Practitioner who, following examination and conversation with mum, advised her that there were significant safeguarding concerns. Upon hearing this Ben's mother became very upset, agitated and distressed. The nurse explained at the Learning Event that she had communicated the concerns to the family alone and she said that the situation had been hard to deal with single-handed.

5.7.2 It was therefore discussed whether it would be useful to have a hard-copy guide to the safeguarding process that could be given to parents in such situations for further reference. Sometimes parents' agitation is borne from shock and poor understanding and having some information that they could read through once the initial shock has started to wear off, may help them to understand and reduce agitation. The nurse said that there isn't currently such a guide but one is planned and she would welcome it.

5.7.3 Ben was found to have numerous injuries that were possibly non-accidental. A strategy meeting, which convened the day after his admittance to hospital, is reported to have been well attended but the results of the Section 47 were not available in time. It was also noted that neither the social worker or the police had been present during the medical and there was a suggestion that the hospital information was not clearly presented.

5.7.4 Ben was in hospital for 5 days. The day before discharge a legal planning meeting convened and Section 20 was agreed. No further strategy meeting was convened.

5.7.5 Tameside and Glossop Integrated Care NHS Foundation Trust maintains a thorough discharge policy to *facilitate the safe and effective discharge of babies, children and young people from hospital…*

5.7.6 The policy specifically addresses the discharge of a child who has been subject to child protection concerns. In summary it states that:

- Where child protection concerns have been raised, it is paramount that the child is only discharged to a safe environment. And the child must not be discharged from a ward or Emergency Department without a documented plan for future care of the child.
- Where concerns about deliberate harm have been raised the child must not be discharged until Social Care have conducted an assessment of the of the family, social and Physical environment, to which the child will be discharged.

- If non-organic failure to thrive has been diagnosed the child must not be discharged until a multi-agency discharge planning meeting has taken place and a plan devised for future care.
- A Child in Need planning meeting must be held where concerns have been raised about a child's welfare.
- A written discharge summary detailing concerns and follow-up arrangements must be forwarded to the child's GP on the day of discharge and the health visitor/school nurse must be informed by telephone.

5.7.7 Ben was known by hospital staff to be being discharged into an environment deemed safe by social services under a Section 20 agreement and a written discharge summary was sent to his GP. Under the policy, a discharge planning meeting wasn't required because there were no concerns about Ben suffering a non-organic failure to thrive. However, everyone at the Learning Event was in agreement that one could have convened to:

- share the findings of the medical (which hadn't been available at the first strategy meeting)
- share the findings from the second opinion, which is routinely requested from Alder Hey hospital, and
- discuss the safety plan moving forward.

The investigating police officer expressed that it would have been very helpful to her as the allocated officer.

5.7.8 The next meeting to convene was a placement meeting a couple of days following discharge. In this meeting social care shared information about the boys' routines and follow-up health appointments but only the carers, social worker and parents would have attended.

5.7.9 In summary, although a discharge meeting was not a requirement of the policy, there would have been benefits to its convention. This review has heard of good communication between the hospital staff and social care and of how the discharge was agreed between children's social care and the consultant. However, a discharge meeting would have ensured that all of the relevant professionals involved with Ben were involved in the discharge process.

6 Good Practice

6.1 Good practice[45] has been identified in this case both in the agency reports and during discussions with the professionals involved with both Alex and Ben:

6.2 Professionals adapted well to the Covid pandemic and worked hard to maintain continuity of support.

6.3 School was noted to be a protective factor for Alex and worked hard with her and her family. Other professionals at the Learning Event commented that school had gone *above and beyond.*

6.4 Professionals praised the work of the Family Intervention Worker in both cases.

6.5 The housing officer working with Ben's mother was noted to be particularly good at maintaining contact with the social worker and attending multi-agency meetings.

[45] Good practice in this report includes both expected practice and what is done beyond what is expected.

6.6 The nurse who informed Ben's mother of the safeguarding concerns handled a difficult situation very well on her own.

7 Conclusions and Recommendations

7.1 Both Alex and Ben have been known to support agencies since birth. Concerns have mostly centred around domestic abuse and neglect. Child Protection plans have been discharged but in the case of Alex, repeated concerns have led the family and professionals back to case conference.

7.2 Recurrent re-referrals for both children suggest that professional intervention, although initially successful, has not proven to be effective long term.

7.3 Good practice has been identified in both cases both in agency reports and during discussions with the professionals involved, but learning has been identified about the way that agencies worked together. It has been specifically in regard to the use and timing of strategy meetings, effective use of the Graded Care Profile as an assessment and information sharing tool, improving information sharing with and from GPs and using a child's voice and lived experiences consistently and effectively both to assess and to monitor progress.

7.4 There has been a high degree of cooperation and engagement from agencies and professionals with the review process, and the reviewer would like to thank everyone involved. This good engagement has been pivotal in identifying the learning and it is hoped that this learning will result in intervention being more effective in the long term. This is particularly important to improve the lives of, and reduce trauma for children and families who are repeatedly being re referred to services.

7.5 It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning in this case, and that changes have already been made or are in the process of being made. For example, a new Graded Care Profile screening tool is being trialled and the police have shared training around the use of strategy meetings. These changes will inform and improve future planning of service delivery in Tameside.

7.6 The following **recommendations** adopt the outstanding learning:

1. The partnership should seek assurance that the GCP training package is completed, and post roll-out, should seek to evaluate whether professionals are now understanding the tool and embedding it into their practice effectively .

2. The Partnership should ensure that consultation is had with a number of GP's to:
   - gain a better understanding of the GP roles and responsibilities,
   - to understand what can realistically be expected of GP's in terms of safeguarding, and
   - to learn how other agencies can help them to achieve.

3. A multi-agency audit via the Partnership should consider dip sampling records of strategy meetings and analyse the results to develop an effective training session that will address any inconsistencies and weaknesses in the strategy meeting process.

4. TSCP should seek assurance from partner agencies that staff are being reminded to fully explore the lived experience of a child and to include their findings in all

records including assessments, alongside the voice of the child. A multi-agency audit via the Partnership should consider dip sampling records and assessments to identify and share best practice.

5. TSCP should contact the service manager at Salford Safeguarding Unit to discuss their Child Protection re-referral and step down processes and consider adopting the same or similar procedures.

6. TCSP and partner agencies should consider developing a parent advocate scheme to support families coming to conference.

Appendix 1 – Terms of Reference (ToR)

a) How effective is the strategy meeting process and its alignment to Working Together 2018. Consider:
   - Initial meetings
   - Review meetings
   - Discharge (from hospital) meetings
   - Child Protection Medicals

b) What is practitioners' understanding of historical and multi-agency evidence and the application of thresholds based on their recognition and response to risk (Neglect & Sexual Abuse)
c) Do assessments of children in families where there is domestic abuse and neglect, fully include the voice of the child and do they explore their daily lived experience.
d) Are partner agencies working together to deliver coordinated support and interventions.
e) Did partner agencies review the impact of the support and intervention to allow them to understand and make a difference to the daily lived experience of the child.
f) Consider the multi-agency involvement (from all relevant partner agencies) in the step down process from child protection to child in need, and closure. Are the multi-agency plans that are being put in place, continuing to mitigate and manage risk.
g) A further term of reference was agreed specifically for Child Alex:
   - Consider the implications to practice of the Domestic Abuse Bill that will recognise children as direct victims of domestic abuse.
h) And a further term of reference was agreed specifically for Child Ben:
   - Review the hospital discharge process and the information that is shared with partners agencies who are providing support to that family.
i) Other terms of reference were identified but were noted to be already being addressed via other case review activity and so will not be addressed in this report:
   - Consider the guidance and procedures for dealing with sexually harmful behaviour in children under 12. (Tameside has recognised the need for practitioners to carefully consider the causes of sexually harmful behaviours, including whether the child has been the victim of sexual abuse.)
   - Explore direct work with children to understand causes of sexually harmful behaviour towards peers[46].

[46] The B19 Case Review identified areas 8.1 and 8.2 as a gap and a Task and Finish Group has been created to develop guidance, tools and training to support practitioners to address these issues.

- This particular neighbourhood has a disproportionate number of families open to services[47].

[47] The F20 Case Review identified a need for a Contextual Safeguarding or community based response. It has been discussed at the East Neighbourhood Learning Circle and a strategic group is being set up to agree a partnership response.