NEWCASTLE SAFEGUARDING CHILDREN PARTNERSHIP
SERIOUS CASE REVIEW LAURA
MARCH 2020

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Glossary

Learning Disability:

Use of this term can be confusing as there are several different definitions used throughout the UK and the term is often used interchangeably with learning difficulties. The Disability Act of 2010 states that a person has a learning disability if they have

- a significantly reduced ability to understand new or complex information or to learn new skills;
- a reduced ability to cope independently;
- an impairment that started before adulthood, with a lasting effect on development.

This means that a child or adult with a learning disability will find it harder to understand, learn and remember new things and may have problems with communication, understanding risks or managing everyday tasks.

The term 'learning disability' is usually used within the context of health and social care where assessments will usually refer to mild, moderate, severe or profound learning disabilities. This term is used throughout this report.

Learning Difficulty

Schools and education professionals tend to use the phrase 'learning difficulties' to describe children who learn at a slower pace than their peers,

Within an education context, learning difficulties are not fixed but can vary according to the environment, teaching methods, and the presence or absence of social and emotional factors. Learning difficulties cover a wide range of needs, including specific learning difficulties (such as dyslexia and dyspraxia), moderate learning difficulties, severe learning difficulties and profound and multiple learning difficulties.

SEND Code of Practice

The SEND Code of Practice was implemented in 2014. It provides statutory guidance, on the duties, policies, and procedures relating to Part 3 of the Children and Families Act and associated regulations, which apply to England.

The regulations are:

- The Special Educational Needs and Disability Regulations 2014
- The Special Educational Needs (Personal Budgets and Direct Payments) Regulations
- The Special Educational Needs and Disability (Detained Persons) Regulations 2014
- The order setting out transitional arrangements

It includes guidance relating to disabled children and young people as well as those with Special Educational Need (SEN). The code provides for additional supportive requirements; where a disabled child or young person requires special educational provision, they will also be covered by the SEN definition.

Special Education Needs

A child is considered to have special education needs if they are of compulsory school age and:

- has a significantly greater difficulty in learning than most others of the same age, or
- has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions

Educational Health and Care Plan (EHCP

An Education Health and Care Plan is for children and young people who have a level of special educational needs that cannot be met through the resources available within a mainstream school or similar setting and who therefore require special educational provision to be determined by the Local Authority. The EHCP is a legal document written by the Local Authority. It is intended to ensure that children and young people receive the additional provision they need, and that education, health and care services work together to provide coordinated support. EHCPs replaced Statements of Special Educational Need in September 2014.

Child Sexual Abuse (CSA)

Sexual Abuse [1]Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether the child is aware of what is happening. Where 'sexual abuse is perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, the term familial sexual abuse is used[2].

Familial CSA is where abuse is perpetrated or facilitated by a family member or someone otherwise linked to the family context or environment.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity, and impulsiveness. Symptoms of ADHD tend to be noticed at an early age and may become more noticeable when a child's circumstances change, such as when they start school.

[1] *Working Together to Safeguarding Children 2015, 2018*

[2] *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action Children's Commissioner: November 2015*

1. Local Safeguarding Children Boards (LSCBs) and Serious Case Reviews

1.1. The main responsibilities of Local Safeguarding Children Boards (LSCBs)[3] at the time this SCR was commissioned were to co-ordinate and quality assure the work of member agencies to safeguard children. The statutory guidance, which accompanies legislation and underpins the work of LSCBs, set out its expectation that LSCBs should maintain a local learning and improvement framework so good practice can be identified and shared.

1.2. In situations where abuse or neglect of the child is known or suspected and children die or are harmed, LSCBs are required to undertake a rigorous, objective analysis of what happened and why, to see if there are any lessons to be learnt which can be used to improve services in order to reduce any future risk of harm to children. There is an expectation that these processes known, at the time, as Serious Case Reviews (SCRs) are transparent, with the findings shared publicly.

1.3. This SCR was commissioned in May 2018 in line with statutory guidance in place at the time.[4] The statutory guidance has now been updated and with effect from September 2019, arrangements for undertaking local reviews where a child has died or been seriously injured have been amended. Local reviews in future will be referred to as local Child Safeguarding Practice Reviews.

2. The circumstances which led to this review

2.1 Laura was diagnosed with ADHD and a learning disability in early childhood. As she grew older, the family was in receipt of various services in response to Laura's special educational needs, some reported behavioural and language difficulties and her frequent presentations for minor ailments at her GP practice.

2.2 Laura lived with her mother, (ML) and her older half sibling (HSL) in Area1. She had no contact with her birth father who left the family when she was a young child. Agency records are vague, but it appears that ML began a relationship with BML, sometime around the beginning of 2010, when Laura was 11 years old. BML had an address over 30 miles away in Area2 although professionals who knew the family believed him to be living with ML. Unknown to the family or any of the professionals working with Laura and her mother at the time, BML was a registered sex offender[5], regularly visited by police in his 'home' town (Area2) in line with multi-agency public protection arrangements (MAPPA)[6]. BML repeatedly reported to officers on these occasions that he had no contact with children and was not in a relationship with anyone.

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[3] *Children Act 2004, s14*

[4] *Working Together to Safeguard Children 2015 HMSO,*

[5] *Registered sexual offenders are required to notify the police of their name, address and other personal details, under the terms of the Sexual Offences Act 2003. The length of time an offender is required to register with Police can be any period between 12 months and life depending on the age of the offender, the age of the victim and the nature of the offence and sentence they received.*

[6] *Multi Agency Public Protection Arrangements or MAPPA is the process through which the police, probation, and prison services work together with other agencies to assess and manage violent and sexual offenders in order to protect the public from harm.*

2.3 Police intelligence led to BML admitting, in late 2017, that he had been in a relationship with ML for seven years and she had a daughter who at that time was 19 years old. Police gave BML the option of telling ML about his history, but he declined to do so, and ML was informed by the police about her partner's background. When asked by her mother, Laura disclosed a history of sexual abuse by BML spanning several years. ML immediately ended her relationship with BML.

2.4 In April 2018, relevant key agencies attended a Case for Consideration meeting in Newcastle. An initial review of the involvement of key agencies in the family highlighted what were some missed opportunities when professionals may have been alerted to what was happening to Laura at home. Those present agreed that the criteria were met for a serious case review. The independent chair of NSCB concurred with this view on 30.4.2018 and a review team led by an independent chairperson was established.

2.5 The serious case review examined professional practice and decision-making from between **January 2010** around the time ML's relationship was thought to have begun to **June 2017** when Laura disclosed sexual abuse by BML. Reviewing practice and systems from such a long time ago brings its own challenges but agencies considered there could still be useful learning, which could support improvements in how children are safeguarded in Newcastle today.

3. Family Involvement

3.1. Laura and her mother were contacted on three occasions to ask if they would like to contribute to this report and have their views represented. Following the conviction of BML in late 2019, both adults told Laura's social worker and the NSCB that they did not wish to be involved in the process and consequently this report does not have the benefit of their insights or reflections about professional involvement during the period under review.

4. Parallel proceedings

4.1. The review team considered a request from the police to delay the completion of the SCR and to restrict its scope in terms of working with practitioners some of whom were likely to be called upon to give evidence in criminal proceedings.

4.2. A decision was taken by the review team and endorsed by the Chair of the LSCB that the SCR process would continue as far as it could until the court hearing relating to BML was concluded. Until that time, it was agreed there would be no contact with Laura or her mother and no request for the practitioners to meet as part of the SCR process. It was also agreed that any learning to emerge in the interim should be addressed and not put on hold until SCR had concluded.

4.3. In September 2019, BML was convicted of 20 sexual offences against Laura and received a custodial sentence of 23 years.

5. The approach used

5.1. This SCR used a systems methodology to look at not only what happened to Laura but also to try and understand some of the factors that influenced why professionals acted as they did or why they did not act at all. An independent reviewer with no links to any of

the agencies involved in the SCR was commissioned to lead the serious case review process.

5.2. A review team of senior professionals representing the agencies that were or had been involved with the family was established. Their role was to provide a source of high-level strategic information about their own agency and their involvement with Laura and her mother through their contributions to the SCR process and the submission of an agency learning report. The review team gathered and analysed data, appraised practice and agreed the content of this report. The agencies represented on the review team are listed in Appendix 1.

5.3. Members of the review team also identified practitioners from their own agencies who knew or had worked with Laura and her mother during the period under review. These practitioners were known as the 'Practitioner's Group' and attended an initial introductory session just to be briefed on the SCR process. This group then met on two subsequent occasions to discuss learning from the review and explore whether single and multi-agency systems in place in 2019 support best practice in protecting children with disabilities who may be at risk of significant harm.

5.4. The review team allowed key issues to emerge as the review team began to pull together information about agency involvement and professional's understanding of Laura's situation. This approach allowed a wider exploration of events rather than a pre-determined focus on specific issues without understanding what happened, when and why. The review team agreed however that the key lines of enquiry should be around:

- how well Laura's vulnerabilities and any related risks were understood by professionals
- whether opportunities were missed which may have alerted professionals to what was happening to Laura
- what factors influenced professional judgements and decision-making
- how knowledgeable were professionals about familial sexual abuse and the modus operandi of sexual offenders?

6. What was known to agencies?

6.1. This section provides a brief narrative of what was known by agencies and what was recorded about Laura in the period under review. Where relevant, some references are made to events, which took place prior to January 2010.

Health: NHS Foundation Trusts (FT1 and FT2)

6.2. In early childhood, Laura, was assessed by FT1 as having learning difficulties, ADHD and speech and language difficulties. In 2009, aged 11, Laura was also diagnosed with a neurodevelopmental disorder and was formally assessed as having a 'moderate to severe learning disability.' Specialist speech and language intervention was provided by FT2 during two episodes between 2006 to 2015. Laura's health needs meant she regularly attended hospital appointments for check-ups and assessments.

6.3. Throughout her involvement with both Trusts, there are some recorded references to Laura being anxious meeting new people or when faced with unfamiliar situations but generally records indicate she responded well to the clinicians she met on a regular basis. Medical records also indicate that Laura attended appointments with her mother

or her support worker but from 2011, some medical records began to refer to her being accompanied on visits with her 'dad' or 'stepdad'.

6.4. A Consultant Paediatrician (CP1) saw Laura on a regular basis. Both ML and BML attended an appointment with Laura in July 2011, and records refer to BML stating that Laura was now more independent with the support he was providing to the family but that he found she was calmer when on medication. CP1 records state that Laura was very relaxed, chatty, and happier than she had been on previous occasions; agency records state she was prescribed Ritalin so she could have '*better grip on learning at school*'.

6.5. In January 2012, concerned to hear of her hyperactive tantrums at home and her quiet and timid behaviour at school, CP1 referred Laura to a Consultant Neuropsychologist (CP2) for an assessment of her '*learning, behavioural and emotive and coping state'*. CP2's assessment highlighted no specific concerns and observed that Laura did not report any greater level of stress than would be expected in any child with significant learning problems.

6.6. In January 2013, when Laura was 14, CP1 noted an increase in Laura's anxiety that seemed to indicate she was not coping well at school. CP1 contacted SCH2 to discuss Laura's needs and was informed that Laura was in receipt of appropriate support services and her needs were continually being reviewed.

6.7. There are no concerns noted in the records of FT1 or FT2 records in respect of Laura's safety, care or well-being, although professionals in both trusts were aware of the difficulties ML said she had in managing her daughter's behaviours. The review team has Agency Learning Reports for both trusts and copies of key documents, which relate to Laura's diagnoses and assessments.

GP Practice

6.8. Laura has been registered with the same GP practice since birth. Between 2010 and 2017, Laura attended the GP practice on 69 occasions mainly for sore throats and ear infections, and from 2013 until 2017, Laura also presented at the GP surgery on 12 occasions with genito- urinary symptoms.

6.9. The family's GP practice is a large one employing several medical practitioners and Laura did not necessarily see the same GP or practice nurse at each visit. Both ML and Laura were well known at the surgery and would often be offered appointments at very short notice. ML had her own health issues, but the review team was told she was thought to be a caring and concerned parent.

6.10. The review team have an Agency Learning Report for the GP practice and a chronology outlining Laura's contacts.

Education and Schools

6.11. Laura initially had a statement of special education needs (SEN) which meant she was part of a statutory monitoring process (SEND) to ensure her education needs were regularly reviewed. She attended mainstream schools, SCH1 (primary) and SCH2 (secondary) from 2009 – 2014 where ongoing support was provided to Laura and (her) ML.

6.12. SCH2 records describe Laura as a gentle and exceptionally well-behaved child who attended school regularly and had no unauthorised school absences. In 2011, school

records indicate that Laura arrived at school with bruising around her eye and told two members of staff that her mother's boyfriend had hit her across the face three times. SCH2 took appropriate action. They first tried to contact Laura's social worker (SWD1) but not being able to make contact; they appropriately contacted the duty team. A duty officer rang back to advise that further enquiries were to be made by the Initial Response Service (IRS)[7]. Two days later SCH2 was informed there was to be no further action and SWD1 had been informed about the referral.

6.13. Records from SCH2 also refer to a second incident in 2013 when Laura was 15 and told staff that her mother had tried to strangle her. The school made a referral to IRS and a duty officer spoke with ML on the telephone, but no further action was taken, and ML was signposted to other services for support with her daughter's behaviour. There were no other safeguarding concerns recorded.

6.14. As she grew older, education records indicate that a decision was taken in consultation with all parties, that Laura's education and social needs could be better met in a school, which catered specifically for young people with learning disabilities. Consequently, Laura transferred to SCH3 in September 2014, a special school for children with multiple learning difficulties, which also prepared students for transition to work and college. Laura joined a small class of 10 students all of whom, according to school records, had moderate to severe learning difficulties. Laura began to attend some classes at a local college, which provided off-site learning under the coordination and management of a class teacher in SCH3.

6.15. Records from SCH3 indicate that Laura settled in quickly and was described as a confident and resilient pupil with no presenting behavioural difficulties. ML, the only named contact listed in school records, was a frequent visitor to the school and staff were aware that ML struggled at times to cope with her daughters' behaviour. According to staff at SCH3 they were also aware that BML lived with the family and Laura often referred to him as 'dad'. SCH3 considered they had a good relationship with Laura and her mother and confirmed they had no safeguarding concerns about Laura or believed she was in anyway at risk from BML. Given the sex education sessions that Laura had attended, staff from SCH3 believe that if she had been able to disclose what was happening at home, she had several opportunities to do so.

6.16. In line with changes in legislation[8], Laura's SEN plan was transferred to an Education, Health, and Care Plan (EHCP). Laura's 'first' ECHP is dated March 2015. In that plan, Laura refers to BML as Dad and states that her 'dad 'plays with her and they take the dog for walks together.

6.17. The review team has an Agency Learning Report for SCH3 and have copies of Laura's SEN statements and EHCP plans.

Children's Social Care (CSC)

6.18. In October 2009, CSC undertook an initial assessment in response to a referral from SCH1 after a parent had reported that Laura had told her daughter that she was being hit by ML's [then] partner. When Laura was spoken to about this in the presence of ML, she said she had made up the story and had told lies. The initial assessment noted that

[7] *The Initial Response Service in place at the time responded to contacts and referrals and determined if assessments of need or risk should be undertaken.*

[8] *The Children and Families Act (September 2014) mandated that the needs of children and young people should be assessed through EHCPs instead of Sen.*

ML was struggling to manage her daughter's behaviour and referred to a report by CP1, which suggested that ML '*may lack understanding of her daughter's condition'.* The social worker recommended that as *Laura* did not meet the criteria for support from the 'Children with Disabilities Team' (CDT), her needs would best be met by CAMHS and health services.

6.19. Agency records suggest that BML joined the family sometime early in 2010. During the period under review, IRS had three further contacts with the family. The first of these was in March 2010, when ML requested help from CSC in relation to Laura's behaviour at home. It was agreed that the play centre, which Laura attended, should start a CAF[9], although the review team could find no evidence that this process was ever initiated.

6.20. The second contact was in May 2011 in response to a referral from SCH2 when Laura presented at school with bruising to her face and told staff that her mother's partner, BML, had caused the injury. This referral led to an initial assessment, which was undertaken by a senior practitioner (SP1) who no longer works for the authority. SP1 recorded that mother's partner, BML did not live in the family home, and the explanation of rough play between him and Laura was accepted, with '*advice given'* about '*playfighting'* and '*overzealous play'*. The case was signed off by a Team Manager and closed two days after the initial referral.

6.21. The third contact was received in July 2013 from SCH 2. Laura had alleged that her mother had tried to strangle her, and the duty officer contacted ML by telephone for more information. ML admitted using physical chastisement and again requested support describing how difficult Laura was at home. A CAF was again recommended, and an early Intervention worker was assigned to work with the family. ML declined the support offered and no further work was undertaken. There were no other statutory interventions until 2017 when BML was arrested.

6.22. The review team has an Agency Learning Report for CSC and have accessed copies of the two initial assessments and a record of the response to SCH2 in 2013.

Northumbria Police

6.23. BML was registered as a sex offender in 2002 and was therefore required to comply with notification requirements under Part 2 of the Sexual Offence Act 2003. When he travelled from Area1 to Area2, he was managed by police as a medium risk sex offender under Multi Agency Public Protection Arrangements (MAPPA) level 1 and was visited on a 6-monthly basis at his address Area 2, some 35 miles from Area1. Police records indicate that BML appeared compliant with the MAPPA process; he repeatedly denied he was in a relationship or that he had any contact with children. His laptop was regularly scrutinised, and his accommodation routinely searched.

6.24. In December 2016, following a visit under MAPPA arrangements, a neighbour told police that BML did not appear to live there but turned up every few days, changed clothes and then left again. The neighbour also reported that he was sometimes in the company of a young female. On one occasion in early 2017, three teddy bears were found on a bed in a room, but police records indicate that BML '*would not say very much about them*'. The information in the Agency Learning Report refers to police

[9] *The* ***Common Assessment Framework*** *(CAF) was at the time, a nationally standardised approach to conducting an assessment of the needs of a child or young person and deciding how those should be met. Developed for use by practitioners across agencies, the CAF was intended to facilitate communication, promote early intervention for families and to prevent an escalation of needs.*

officers having '*suspicions*' that BML was in a relationship but without any evidence, the review team was told they were unable to take any action.

6.25. Police intelligence received in July 2017, led police to question BML, whereupon he admitted he had been in a relationship with ML for over 7 years and she had a daughter who at that time was 19 years old. It appears that Laura's young niece would also visit at times but BML denied being alone at any time with either child... BML was arrested and Laura disclosed to her mother and later to police and a social worker the extent of the abuse to which she had been subjected for several years. The review team was told that police and CSC enquiries in relation to Laura's niece found no evidence to suggest that the child had been subject to abuse by BML.

6.26. The review team has an Agency Learning Report for Northumbria Police.

7. Analysis of practice

7.1. It is important to recognise how much hindsight can distort judgment about the predictability of an adverse outcome. Once an adverse outcome becomes known, there can be a tendency to look back over the history of the case and pinpoint certain actions or moments which are thought to be critical in leading to that outcome. Hindsight-bias can also lead to a false reassurance that what happened was predictable and therefore could have been prevented. The review team was particularly mindful of the dangers of hindsight- bias and every attempt was made to keep an open mind to understand why certain actions and decisions in relation to Laura would have made sense to professionals at the time.

7.2. The review team confirmed five key lines of enquiry (KLE), which provided a framework with which to appraise practice:

KLE 1: The extent to which professionals recognised Laura's vulnerabilities and any risks to which she could be exposed.
KLE 2: The opportunities which could have alerted professionals to the need to be curious about what might be happening to Laura
KLE 3: The factors, which influenced professional judgments and decision-making
KLE 4: The 'background' male in Laura's family
KLE 5: Professional knowledge and understanding about familial sexual abuse, the modus operandi of perpetrators.

7.3. ***KLE 1: Recognition of Laura's vulnerabilities and risk factors***

7.3.1. The term 'vulnerable' is used in many different ways – from '*disadvantaged children who would benefit from extra help in order to make the best of their life chances'*, to children with '*complex needs*' or those '*living below the poverty line'*.[10] In one sense of course, all children are vulnerable because of their age, early developmental status, and their dependence on adults for their care and protection. Laura however, had additional vulnerabilities because she had been diagnosed at an early age with ADHD and a learning disability which impacted on her capacity to learn new skills, retain and communicate information and, as she grew older, to live independently.

7.3.2. 'Learning disabilities' and 'learning difficulties' are terms that are often used interchangeably and how and when each term is used remains subject to continual national and local debate. In education, a learning difficulty is used to describe

[10] *Anne Longfield, Children's Commissioner July 2017*

specific problems with learning, such as dyslexia or dyspraxia, but individuals with these challenges, do not necessarily have a '*learning disability*' which is generally defined in the UK as meeting three specific criteria[11];

- *'a significantly reduced ability to understand new or complex information to learn new skills (impaired intelligence) and,*
- *a reduced ability to cope independently (impaired social functioning) which…*
- *started before adulthood and has a lasting effect on development*.'

7.3.3. Throughout the review process, there were frequent references to the challenges for professionals about how the terms '*learning disability'* and *'learning 'difficulty'* were understood and applied by different agencies. Whilst it is outside the scope of this SCR to propose how and when each term should be used, the review team did agree that this is an area of increasing frustration for professionals. The review team was told that the work underway [12] by key agencies in Newcastle to clarify and agree usage of both terms is welcomed. The review team agreed that for this SCR, the term 'learning disability' as it applies to Laura, was appropriate to use for this report.

7.3.4. Laura appears to have been diagnosed, at the age of 7 with attention deficit hyperactivity disorder (ADHD), which is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity, and impulsiveness. According to agency records and conversations with practitioners, ML asserted that the combination of having ADHD and a learning disability impacted upon Laura as she grew older and resulted in behaviours at home which ML found difficult to manage.

7.3.5. It is clear from agency records and initial conversations with practitioners, that Laura's vulnerabilities, which stemmed from her disabilities were well understood; there are numerous records, reports and assessments which refer to the difficulties and challenges Laura faced in her day to day life as she grew up. In response to these, Laura received appropriate services from key agencies, which sought to support her developmental and education needs.

7.3.6. There is a wealth of research, which indicates that disabled children are a particularly vulnerable group, with a significantly greater risk of physical, sexual, and emotional abuse and neglect than non-disabled children[13]. Research shows that children with disabilities are three times more likely to be abused than non-disabled children and are more likely to be abused by someone in their family compared to non-disabled children. These risks are further heightened where the child has behavioural and language difficulties. [14] [15]

7.3.7. Despite this, children with disabilities remain under-represented in child protection processes and are over-represented in Serious Case Reviews. The review team acknowledged that Laura's vulnerabilities were well recognised by professionals but would suggest that the potential risks of sexual abuse were not as well considered by professionals who knew the family, as well as they might have been.

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[11] *National Institute for Health Care and Excellence ' Learning Disability' (2018)*

[12] *Multi-Agency Working Party 2019 (ADD DETAILS)*

[13] *Intra-familial child sexual abuse: Risk factors, Indicators and protective factors Research in Practice (2018)*

[14] *We have the right to be safe' Protecting disabled children from abuse. NSPCC: Miller and Jon Brown (2014)*

[15] *Protecting disabled children: Ofsted Thematic Inspection 2012*

7.3.8. Laura's vulnerabilities together with other family and contextual factors actually placed her at higher risk of abuse than her peers; ML was a single parent who was known to have very little support from her own family; her two prior relationships before she met BML appear to have been difficult and very possibly abusive. Professionals who knew ML described her as a caring and concerned parent but one who at times struggled with Laura's behaviours. These were additional risk factors, which should have alerted all professionals to the heightened risks of abuse for Laura, as she grew older, especially given her reported behavioural difficulties at home. An additional and well-documented risk factor, which increased risk of abuse even further, was the presence in the home of a non- related male partner.

7.3.9. Whilst these individual factors are known to increase the risk of child abuse, their presence does not necessarily mean that abuse or neglect will occur. Practitioners are however expected to use their professional judgement to assess their significance in each child and to understand how separate factors can combine to increase the risk of harm, especially to a child with disabilities. The key question, of course, is when and what should trigger alarm bells for professionals to begin looking for indicators of sexual abuse.

7.3.10. From agency records and conversations with professionals who knew Laura, it was clear there were no obvious signs or symptoms to suggest that she was in any way at risk from ML or BML or that she was being sexually abused by him or indeed anyone else. Laura appeared well and happy for most of the time and on the occasions when she did appear distressed or unhappy, professionals responded appropriately but for the most part, had no specific concerns about her safety and welfare. Agency records indicate that ML reported difficulties in managing Laura's behaviour from an early age even before BML became involved with the family. As far as SCH3 were concerned, BML was already firmly established in the family when Laura came to their school and they reported they had no reason to question his involvement in the family.

7.3.11. Professionals told the review team that the possibility of sexual abuse was never considered as a possible hypothesis for some of her reported challenging behaviours at home. Equally, BML was never thought of as a risk factor and he appeared as a supportive adult to both Laura and ML. Laura's apparent 'difficult' behaviours as she grew older seemed to be attributed to her ADHD and learning disability diagnosis and a lack of structure and consistency in the home environment. Consequently, the reasons for Laura's 'difficult' behaviours as reported by ML, were never fully explored, or queried in any depth by professionals involved with the family.

7.3.12. Whilst, it is only with hindsight that some of Laura's 'behaviours' are now viewed as significant; the review is nevertheless a stark reminder to professionals of the importance of keeping an open mind and a healthy sceptism in all families where 'difficult' behaviours of children are identified.

Finding 1: *Laura's learning difficulties were well understood, but not all professionals demonstrated an awareness that Laura was at heightened risk of sexual abuse in her family. A lack of awareness about sexual abuse of children with disabilities among professionals contributes to their vulnerability.*

This was a finding that resonated with practitioners and the review team and going forward, continues to have implications for practice in Newcastle in 2020.

7.4. KLE 2: Whether opportunities were missed which may have alerted professionals to what was happening to Laura

7.4.1. The review team identified several missed opportunities, which may have alerted professionals to what was happening to Laura at home and wanted to understand why these were not picked up at the time.

7.4.2. The injuries to Laura's face in May 2011 inflicted by BML should have led to a strategy discussion and a decision to undertake s47 enquiries.[16]. This would be expected practice. Laura was clear in what she said to staff at SCH2; her mother's partner, BML had hit her three times across the face and bruising to her cheek and eye was clearly visible. The review team was unable to determine why, instead of a strategy discussion, the duty manager instructed a senior practitioner (SP1) to make an initial assessment and find out who was living in the home. SP1 did as requested and was told that BML was ML's boyfriend but he did not live in the home although he did spend time there and the injuries occurred as a result of *'play-fighting'* between BML and Laura. At this point, Laura would have been 13 years old.

7.4.3. Without the benefit of SP1's input, the review team can only assume that this information and the conversations held with, BML, ML, and Laura reassured SP1 to such an extent that she felt it unnecessary to collect any information about BML other than his first name. This was not, however in line with expected practice, and was a missed opportunity to learn more about a significant non- related male in Laura's life and one who had caused her physical harm. After the visit, SP1 reported to the duty manager, having spoken with SCH2 and CP1 and suggested that a CAF should be undertaken, although it was not clear who would progress this. SP1 recommended closure of the case.

7.4.4. Had there been a strategy discussion in response to Laura's injuries, which would be expected practice, further details about BML would undoubtedly have been sought and Laura would have received a medical to ascertain the extent of her injuries. Police records indicate that BML had changed his name by deed poll and there can be no certainty that had information about BML been shared, his sex offender status would have emerged, especially given his 'home' was in another area 35 miles away. However, it is equally possible that additional background information may have emerged which could have led to a different outcome for Laura. Instead, BML was given 'advice' about his rough play with Laura and the case was closed.

7.4.5. At the time the 2011 assessment was undertaken, initial assessments were subject to tight timescales. In response to contacts by other agencies, decisions had to be made within 24 hours about the action to be taken and referrals and initial assessments had to be completed within 10 days [17]. Whilst, the difficulty of needing

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[16] *The purpose of a Strategy Discussion (or Meeting) is for police and children's social care to consider, alongside other key agencies, how best to respond concerns when there is evidence or a suspicion that a child or children has suffered, or may have suffered, significant harm.*

[17] *Department for Children, Schools and Families [DCSF], 2010)*

to make professional judgements quickly and without scope for reflection, the failure to gather even the most basic of details about BML suggested the risks to Laura were neither recognised, understood or fully assessed. SP1 no longer works with the authority, so the review team was unable to fully appreciate the context of how or why certain decisions made sense at the time but were of the view that the authorising and signing off the assessment also highlighted significant shortcomings in managerial practice.

7.4.6. The role of the Team Manager is to ensure good outcomes for children and manage staff performance, resources and budgets. Team Managers are also required to supervise staff, have managerial oversight, and sign off all assessments. The lead reviewer and another member of the review team met with TM1, the team manager who authorised and signed off the assessment undertaken by SP1 in May 2011. Although no longer working for the authority, the review team are grateful to TM1 for his willingness to contribute to the SCR and reflect on his own practice and the context in which he was working at the time.

7.4.7. TM1 told the review team that his recollection of events was that in response to information from SCH2, the duty manager on that day asked SP1 to go out to the school to gather more information about who lived in the household. TM1 was at that point 'on duty' at the police station screening the Child Concerns Notifications into CSC records and was not consulted about the referral. TM1 indicated that SP1 would, as per usual practice, and have fed back to the duty manager after the visit. TM1's first memory of the assessment was reading through it the next evening noting the recommendation for a CAF and eventually authorising sign off and closure two days after receipt of the referral.

7.4.8. TM1 stated that he was aware that his actions fell significantly short of expected standards and he should have ensured a more robust analysis of the information and made sure that the details of all household members had been appropriately captured and recorded. TM1 said he had thought many times about his actions during the past year, asking himself why he had not been more vigilant. He concluded that one factor was his confidence in and reliance upon SP1 whom he regarded as a competent and experienced professional. TM1 acknowledged that seeing that SP1 had made a recommendation for a CAF, he had not expected to find any omissions or worrying information, and had therefore only skim read the assessment, which led him to miss crucial information.

7.4.9. The central tenet of the systems approach is that a worker's performance is a result not only of their own skills, knowledge, and integrity but is also inexorably linked to the organisational environment in which they work. This approach views people as being part of the system because their behaviour is shaped not only by their own professionalism but also by systemic influences such as workload pressures, capacity issues and the extent to which they are supported through robust supervisory practices.

7.4.10. The review team were curious to discover that Laura's assessment was signed off at 11.00 pm and asked TM1 to explain more about why this was so. TM1 explained that alongside his team manager role he had, like other colleagues, several other duties assigned to his role and he needed to work additional hours to manage his workload. The review team was told that TM1 had 4 formal supervision sessions with his own

line manager between October 2010 and May 2011, although the expectation would have been at least twice this number of sessions given TM1 was a manager new to the role and working in a busy team. TM1 told the review team he had raised concerns with his line manager about his work/life balance and that in order to '*keep afloat'* he usually had to work late in the evening and at home.

7.4.11. The review team have been provided with [redacted] supervision notes relating to March and April 2011 where workload issues are referenced. Other supervision notes were not found. It is important to stress that other managers were at that time also working in the same stressful work environment and TM1 was not the only manager working under pressure with a busy caseload and multiple demands. While it is right to be held accountable for poor practice, it is also unreasonable if poor practice occurs because of an overburdened system. Whilst, these factors do not in any way condone poor practice, they do help to place the actions of TM1 in a much wider context so they can be more easily understood.

Finding 2: *Professionals coping with multiple demands in stressful work environments need access to support and regular reflective supervision. Without this, errors are more likely to occur this can leave children vulnerable.*

This was a finding that resonated with practitioners and the review team and going forward, continues to have implications for practice in Newcastle in 2020.

7.4.12. There have, since 2011, been multiple changes in CSC. Most recently, the regularity of staff supervision is now recorded and monitored by service managers and senior leaders. Audits are regularly undertaken around quality of supervision and there is a much stronger emphasis on monitoring caseloads and ensuring staff under any form of pressure are well supported. These developments are to be welcomed.

7.4.13. The third incident reported to IRS by SCH2 in July 2013 when Laura alleged that her mother had tried to 'strangle' her'. However, this allegation, only led to a duty officer making a phone call to ML who admitted placing her hands around the neck of her daughter in frustration at her behaviour. ML was, according to agency records, told she should find other ways to chastise her daughter and no further action was taken. This was not in line with expected practice and suggested to the review team that Laura's allegations were not considered or taken seriously.

7.4.14. This was the third missed opportunity by CSC to explore family dynamics and find out more about what might be happening in the home. . The review team was unable to determine why a phone call to ML in response to Laura's allegations made sense at the time and this information is not explored in the CSC Agency Learning Report. Had contact been made with other professionals known to the family, additional information may well have come to light.

7.4.15. CP1 had noticed that Laura appeared more anxious than on previous visits and contacted Laura's school where he was reassured that Laura and her family were well supported. This was good practice. Laura had also presented for the first time with a suspected urinary tract infection to her GP surgery and whilst this may not in itself have led to concerns, this information, together with that from the school and

from CP1 should have left a curious practitioner wanting to know more about Laura's circumstances. Without liaising with education or health colleagues, CSC, as a single agency, assessed Laura's allegations and determined there was no cause for concern. Agency records do not provide a rationale for this decision or a manager's challenge to the response to SCH3's referral.

7.4.16. Within the review team, discussions centred around the importance of multi-agency working and views were expressed that processes in place for responding to and managing referrals are now more robust following the introduction of the Multi-Agency Safeguarding Hub (MASH) in 2018. Referrals like those made to CSC in 2011 and 2013 would now be routinely considered by a team consisting of a dedicated police DI, a safeguarding nurse from health, a social worker and education representative.

7.4.17. Between 2013 and 2017, Laura presented at the GP surgery on 12 occasions with genito-urinary symptoms, which were assumed to be urinary tract infections (UTI) and were treated with antibiotics, and/or thrush medication. According to National Institute for Health and Clinical Excellence (NICE) guidelines[18], UTIs are one of the most common reasons why teens, especially girls, visit their GP, and recurring UTIs are not unusual. UTIs also tend to be more common in girls who are sexually active and for this reason; NICE guidelines suggest that all adolescents with UTIs should be asked about sexual activity.

7.4.18. The GP practice managed Laura's regular and recurrent presentations with ear, nose, and throat problems. The response to her recurring genito-urinary symptoms however seems to have followed the same pattern of managing the symptoms as straight forward infections even though out of 9 samples sent to the lab, only 1 infection was confirmed. There was no exploration as to whether Laura's symptoms could be linked to sexual activity and no indication that Laura was ever seen alone or asked, as a young adolescent, if she was sexually active. NICE guidelines advise that sexual abuse should be considered if a child has dysuria (discomfort on passing urine or ano-genital discomfort) that is persistent or recurrent and does not have a medical explanation such as a 'urinary infection... skin condition... or poor hygiene'[19]. The review team was told she was never thought of as a child at risk in anyway and the possibility of sexual abuse was never considered. ML was viewed as a concerning and protective parent.

7.4.19. The review team acknowledged that it is not possible to say with any certainty that Laura would have disclosed what was happening to her had she been asked, and Laura's presenting symptoms are not uncommon in young girls approaching puberty, but nevertheless these were missed opportunities to learn a little more about Laura's lived experiences. The review team was of the view, and this was supported by feedback from professionals, that most other 14 or 15-year-old non-disabled young women presenting with similar symptoms would have been sensitively asked about their sexual experiences.

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[18] *National Institute for Health and Care Excellence (NICE). Urinary tract infection in under 16s: diagnosis and management. 2007 Aug. Updated 2018*

[19] NICE When to suspect Child Maltreatment (2009)

7.4.20. Professionals discussed with each other why Laura, at 15 years old, was not asked about her sexual history, although given she was seen by several medical practitioners over the years, it was not possible to conclude which of these, if any, influenced the response of GPs to Laura's symptoms. One possibility explored was that GPs' may have held a view there was no need to ascertain information about Laura's sexual experience because she was a disabled child, and therefore would not be sexually active; a second possibility centred on the fact that Laura always attended appointments with her mother and it may have been thought that it was inappropriate to ask such a question with a parent present - in which case it would have been appropriate that Laura was offered the option of speaking with the GP/practice nurse alone. A third possibility related to a point made earlier that, without an understanding of the increase risks posed to children and young people with disabilities, medical practitioners were not sufficiently curious about Laura's recurring presentations with suspected urinary infections.

7.4.21. Any one of these possibilities could explain why the recurring genito-urinary symptoms were managed as episodic and straightforward infections without exploring other contributory factors such as sexual activity or even sexual abuse. It was pointed out to the review team, it would be unlikely that in a busy surgery GPs would scroll back through medical records to look at Laura's medical history, unless the presenting symptoms raised specific and ongoing concerns. The review team was also advised that Laura's consultations were so brief that it would have been difficult for any medical practitioner to think more broadly about Laura or have a clear picture of how she presented on these visits.

7.4.22. Being well known to the practice may also have led medical professionals not '*seeing*' Laura and given that she had difficulties with speech and language, it is possible they found it easier to converse directly with ML who mostly came with her to appointments.

7.4.23. GP colleagues told the review team that given the number of times the family came to the surgery; it would not have been possible for them to see the same GP each time. The review team recognised that it can be difficult to see the same GP for most appointments, but for Laura this meant that no medical practitioner in the practice had oversight of her circumstances or her developing needs. From a medical perspective, there is perhaps a suggestion of 'diagnostic overshadowing' where Laura's symptoms and behavioural issues may have been incorrectly identified as being a result of her primary diagnosis of ADHD and her disability rather than in response to something that had happened to her.

7.4.24. The review team queried whether Laura's annual health check highlighted any concerns. Agency records indicate that Laura was subject to a 'Cardiff Health check'[20] when she was 14. However, this process is based on a medically oriented checklist and the notes made at this assessment did not refer to any dialogue with Laura or to her capabilities. The form had not been completed in its entirety and there

[20] *The Cardiff health check has been designed to be an annual health check by doctors and nurses in primary care for people aged 14 years and older with intellectual disability. It aims to provide a systemic physical health check including physical examination, medical review and health check action plan.*

was no evidence that the information was used, going forward to support Laura. The National template for annual health checks for children with a learning disability was however revised in 2017 and now includes a question specifically asking about the risks of sexual abuse and sexual exploitation.

Finding 3: *Professional understanding about the lives and experiences of children with disabilities can impact on all aspects of a child's life. Unchecked assumptions can inhibit professionals from focusing on the child and family and this limits communication and exploration about what may be happening for a child in their family.*

This was a finding that resonated with practitioners and the review team and going forward, continues to have implications for practice in Newcastle in 2020.

7.4.25. Staff in Laura's schools had more day to day contact with her than any other professional and were therefore well placed to identify and respond to any ongoing signs of distress or concern. There were no ongoing safeguarding concerns recorded in any school records, although staff in SCH2 and SCH3 were aware that ML struggled at times to manage her daughter's behaviour and offered extensive support to the family.

7.4.26. When SCH2 reported the injuries BML had inflicted on Laura's face, SCH2 saw no need to challenge the decision by IRS to take no further action, believing that the matter had been fully investigated and was resolved. The review team was told that Laura displayed no signs or symptoms to suggest she was in any fear of BML. The same was true of the referral they submitted in relation ML's assault on her daughter two years later. SCH2 cited Laura's good attendance, her behaviour and happy disposition and ML's protectiveness as indicators that Laura was well cared for and safe at home living with her mother and BML.

7.4.27. There were references by practitioners to Laura's ADHD which, it was suggested meant her 'behaviours' as she approached adolescence, were not seen as symptomatic of anything other than her diagnosis. Although, CP2 advised the review team that it would be unusual for a child with ADHD to present so differently at home and at school, education professionals disagreed and advised that in their experience the structure and routine provided by skilled and experienced practitioners in schools often meant that children's behaviour could be better managed and contained than was possible in the home environment. ML's descriptions of Laura's 'difficult' behaviours at home did not therefore cause concern or consternation by teaching staff in either SCH2 or SCH3. They were also not so dissimilar to behaviours described by the parents of some of the other children who attended SCH3.

7.4.28. There are records in documents provided to the review team that Laura told staff in SCH3 that she was not getting on with her mum's boyfriend and that she couldn't live with her dad anymore. School staff took note of Laura's comments, and although the remarks are not uncommon from many young people of Laura's age, they were considered unusual coming from Laura and indicated a shift in family dynamics, which was impacting on Laura. Staff made a note of these comments and according to agency records 'monitored' Laura for the rest of term. This was good practice. However, no specific concerns emerged which warranted a referral to CSC.

7.4.29. SCH3 did discuss Laura's comments with ML and staff were told that Laura was often jealous of the time she spent with BML. SCH3 told the review team of the difficulties staff can encounter when trying to sensitively 'probe' into family problems, especially when these are not recognised by parents. SCH3 did not consider they had any evidence with which to support a referral, and as Laura's needs never met the threshold for services from the Children with Disabilities team (in Children's Services) Laura did not have a named social worker with whom SCH3 could liaise. Despite being aware that something seemed to be changing in the family, SCH3 told the review team that the possibility of sexual abuse by BML was never considered and had it been so, contact or even a referral would immediately have been made to CSC.

7.4.30. Due to the nature of their work and their experience of working alongside statutory authorities when child protection concerns arise, SCH3 reported that staff were particularly knowledgeable about the increased risks of abuse for all their students. All young people at SCH3 are provided with extensive sex education, which includes helping students recognise sexually abusive behaviours and learn how to keep themselves safe. The students in Laura's peer group were encouraged to talk openly about these risks and explore what actions they might take if they were worried or were being hurt or exploited by anyone. SCH3 reported to the review team that Laura coped well with the subject matter and showed no sign of distress or difficulty.

7.4.31. SCH3 indicated they never had reason to believe Laura was in any way at risk; the review team was told that staff in school encouraged all students to talk about anything which was worrying them and believed that Laura had many opportunities to tell staff what was happening had she been able or chosen to do so

7.4.32. Asked to think about why she had not disclosed what was happening, professionals in SCH3 were clearly knowledgeable about the ways in which perpetrators groom their victims and were of the view Laura could very easily have been persuaded to believe she was in a 'relationship' with BML and to '*keep secrets'*. It was also acknowledged that she may have been fearful of BML and what might happen to her if she told anyone what was happening. Education staff also were of the view that it was very possible that Laura did not recognise, despite her active participation in the sessions about safe touches and keeping safe, that what was happening to her was abuse – a reminder of how skilful perpetrators can be in grooming their victims.

7.4.33. Whilst colleagues in children's services and health have regular and open access to line managers and safeguarding leads, education staff do not have access to the skilled and experienced safeguarding roles outside school settings. This leaves educators without useful opportunities to explore their thinking and/or be challenged or supported about their safeguarding practice. There is no evidence to suggest that had access to such advice been available, the outcome for Laura would have been different. However, the absence of such a resource for schools must limit opportunities for discussions in which their thinking about the nature of some concerns can be tentatively explored and possibly even challenged.

7.4.34. Police had been visiting BML in his 'home' in Area2 for several years as part of MAPPA arrangements. The review team was concerned to note that police records indicate that the Risk Management Officers (RMOs) who visited BML, had suspicions

that he was in a relationship but believed that as there '*was no evidence to substantiate this information*' no action could be taken. The visiting officers also reported that on one occasion teddy bears were found on a bed but BML would 'not elaborate why they were there'. This information, together with intelligence provided by a neighbour in August 2012 that BML came to the property often accompanied by a young female should have raised concerns.

7.4.35. These were clearly missed opportunities to learn about BML's activities which, had they been investigated further, may well have led to protective measures for Laura. Exploring why the attending officers were not more vigilant, the review team were told that because BML was considered 'medium risk, MAPPA visits were undertaken twice a year by two specially trained RMOs. These visits to BML had been happening since 2012 and although the RMO teams were not always the same, there was an expectation that before each visit, the police database would be checked so the RMOs were well briefed about the offender and any concerning activities.

7.4.36. There were clearly some concerns about BML even in 2012. Soon after he had moved to the area, police records indicate that a bid had been lodged by a police officer for '*further enquiries*' to be made. This is the process by which officers can request investigation into an offender's activities and/or lifestyle. According to records this request was made because the officer had not believed the reasons BML gave for needing to move into a different area. The request for surveillance was updated on the police system in March 2012 but the box for authorisation by a supervisor was not ticked. Procedures at the time required such requests to be also submitted separately by email and not just updated on police records. There is no evidence why this procedure was not followed and the individuals who may have cast light on this have since retired.

7.4.37. At no time, since 2012 does it appear that concerns about BML were raised or shared. There is an expectation that any incident or concern involving registered offenders, which could be indicative of a critical incident, is managed accordingly. It would be expected that the relevant manager in the offender management unit would have monitored and reviewed risk around BML, but this does not appear to have happened and concerns clearly were not articulated or shared by any of the officers visiting BML.

7.4.38. The review team was told that although RMOs are specially trained, police officers are perhaps naturally more inquisitive, more suspicious, and challenging. This left the review team to conclude, without being able to explore with any of the RMOs involved, that the risks BML posed were not identified or well understood. However as with TM1, the context in which RMOs were working at the time may have impacted at time on practice. The review team was informed that workloads were high with RMO's having responsibility for 60- 80 medium to low risk offenders in the community. Due to the high numbers of persons requiring to be managed, combined with the administrative burden and the high turnovers of line managers. This, the review team were told, led to an increase in stress and sickness levels for staff, and made it more likely that risks in some situations were not recognised. See Finding 2.

7.4.39. Recognition that changes were needed to strengthen existing arrangements has already led, more recently, to changes in how sexual and violent offenders are managed in the community. The responsibility for managing visits to high and

medium risk offenders has been removed from probation to Neighbourhood Police Teams (NPT) which according to police data, has resulted in more people being arrested for breach of licensing conditions. An administrative function has also been set up which requires the NPT officers to access/view previous Home Risk Reviews/ARMS Assessments and Risk Management Plans within the workplace prior to conducting a Home Risk review so they can familiarise themselves with information regarding the offender prior to undertaking their review.

7.4.40. Police learnt much later of BML's involvement with ML through information provided by a third party. Had that intelligence not been picked up, BML's abuse of Laura would very likely have continued.

7.5. Understanding professional judgment and decision-making

7.5.1. ML and three professionals were consulted as part of the initial assessment in 2011; CP1, Head of Year SCH2 and SWD1, but a good deal of the information contained in the assessment document is cut and pasted from the 2009 initial assessment. Given the detail of Laura's diagnoses, this is understandable in terms of medical reports and assessments but the review team were of the view that SP1's assessment of the situation was not as focused or as robust as it could have been and the 2011 conclusions appear to have been unduly influenced by the findings from an earlier assessment two years previously. The evidence for this lies in the similarity between the two assessments and the copied references to significant events such as Laura's '*killing of the family [pet]'* and reports that Laura *'cries at school and home but wouldn't say why*. These incidents were included in both assessments but were neither commented upon nor analysed as to their significance.

7.5.2. Laura's medical and educational history is clearly outlined in the 2011 assessment but there is little exploration of the family dynamics or relationships either within the family or with any extended family members. Laura's half sibling, older by several years, also lived in the family home but is mentioned only briefly and there are no details at all about BML. There is no evidence that Laura was seen alone and although it appears from agency records that SP1 came to school to take her home following the referral, the initial assessment document makes no reference to any conversations which may have occurred on the journey.

7.5.3. Without any indication that Laura was seen alone, her views are represented only through ML rather than from Laura herself. Although described in the assessment as '*ruling the roost'* and '*being rude'*, this information, like some others, appears to have been cut and pasted from the earlier assessment. The explanation that BML hit Laura three times across the face whilst '*play fighting*' was accepted with reproof, but without question and the references to Laura having no inhibitions about rough play clearly placed some of the responsibility for the injuries onto Laura herself.

7.5.4. The review team concluded there was evidence here of a less than objective assessment, possibly influenced by the fact that the information received from CP1 and SCH2 confirmed Laura had long standing behavioural difficulties and had a 'learning disability'. The absence of curiosity or any exploration around BML in the 2011 assessment suggested to the review team that SP1 might have held pre-conceived assumptions about the nature of the referral, very possibly because of

previous assessments, suggesting not only a lack of curiosity but also a form of 'confirmation bias'.

7.5.5. Confirmation bias[21] compels practitioners to ignore information that goes against first impressions or judgements. Research and serious case reviews have highlighted the tendency of professionals in all agencies to develop fixed ideas about a child's situation and to stick to an initial view, taking account of supporting information but unconsciously rejecting any information which 'does not fit'. Ideas about a child's situation and welfare can be heavily informed by intuition, which whilst based on experience, can also be influenced by professional bias.

7.5.6. There is evidence[22], which suggests that assessments can be too focused on the content of the referral – the immediate issue – while failing to consider in enough depth the case history. However, in the 2011 assessment, the review team found that there was insufficient focus on the reason for the referral, namely the injuries which had been inflicted on Laura by BML. Whilst the assessment contained a wealth of information relating to Laura and her 'history', there was no exploration about family relationships or how and where BML fitted with the family. There is no evidence of any reflective or critical thinking in the 2011 assessment despite the volume of information contained within it.

7.5.7. Fish[23] suggests that professionals need to take active steps to work against '*our human tendency to seek only the information that we wish to find' and* confirms the dangers of a tendency to *'stick to what we think we know'* and carry on work with a family without question or challenge. She goes on to state '*one of the most common, problematic tendencies in human cognition ... is our failure to review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture*.' SP1 no longer works with the authority, so the review team were unable to learn how or if these biases may have impacted on professional judgment.

7.5.8. The importance of professional curiosity is well documented in work with children and families. It refers to the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This has been described as the need for practitioners to practice 'respectful uncertainty' or 'healthy sceptism' and applying critical evaluation to information received, maintaining an open mind. In safeguarding the term is used to describe an approach which is focused on safety but one that considers changing information, different perspectives and acknowledges that certainty is rarely a given in this area of work.

7.5.9. Although Laura's vulnerabilities were well recognised by the professionals with whom she came into contact, no professional considered the possibility that sexual abuse could be one explanation for her behaviours at home, her presenting medical problems as an adolescent or the complaints she was making about her 'dad',

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[21] *Gambrill, E.D. (2005) 'Decision-making in child welfare: errors and their context', Children and youth services review, vol 27,*

[22] *Seden, J. (2106) 'Social work: risks, needs and balanced assessments', K216 Readings, Milton Keynes, The Open University.*

[23] *SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews*

however typical these appeared to be. There are of course, dangers in presuming that sexual abuse has taken place but equally an abnormally low level of alertness to the possibility may lead professionals to miss signs or misread attempts by children who are testing the water to gauge whether they can trust an adult if they choose to tell what is happening.

7.5.10. One of the known factors that can increase risk and lessen protection include the attitudes and assumptions of parents and professionals who may struggle to accept that children with disabilities can be abused and attribute indicators of abuse to the child's disability. Laura was diagnosed with ADHD and a learning disability when she was young and the naming of her 'conditions' may well have distracted professionals' attention from thinking more deeply about what may have been happening in her life.

7.5.11. The review team found that there were frequent references in agency records to Laura's 'difficult' 'aggressive' and 'acting out' behaviours when at home, although there is evidence that these behaviours were present before ML's relationship began with BML. The review team queried whether the diagnosis of ADHD and a moderate to severe learning disability as a medical diagnosis allowed professionals to be less curious than they might have been about the reasons for Laura's 'difficult' behaviours. The risk, of course, for children with '*labelled conditions'* is that their basic needs or problematic behaviours, which have nothing to do with their condition, can be overlooked by professionals who focus more on the perceived problems arising from the 'label' rather than looking for other possible alternatives. Reading through case notes and assessments, there is very little exploration or descriptions of Laura's actual behaviours or the context in which they occurred.

7.5.12. The information gathered by the review team from records, reports and conversations with practitioners highlight not only Laura's vulnerabilities but also the ongoing care she was reported to be receiving from her mother, who was clearly seen as a protective and concerned parent. In contrast to her reported behaviour at home, Laura was consistently described in school records as a lively but generally well behaved and co-operative child. Upon reviewing the integrated chronology, the review team observed how often during the period under review and in the preceding year, ML had asked for help in managing her daughter's behaviour and how often no services seem to emerge or were taken up by ML, when offered. There were three specific references indicating that the family would benefit from a CAF, but no agencies pursued this and no CAFs ever materialised. The review team were left with a sense that ML's assertions about Laura's difficult behaviours were not perceived in any way as being located with the family setting but were viewed more as an aspect of Laura's own disabilities.

7.5.13. The review team explored with practitioners whether they thought they had been 'curious enough' about Laura's life. Discussions highlighted that Laura was regarded as a well- cared-for child who showed no fear or hesitancy about BML or any other adults and other than ML struggling at times to cope with her behaviour at home, no safeguarding concerns had ever emerged. The review team was told that whilst the review process had reminded them of the need to continually maintain a stance of professional curiosity, such an approach has its challenges.

7.5.14. Professional curiosity is a combination of looking, listening and asking direct questions and reflecting on the information received. The learning from case reviews,

both nationally and locally, highlights that responding to presenting issues in isolation and a lack of professional's curiosity can lead to missed opportunities to identify less obvious indicators of vulnerability or significant harm. Views were exchanged in the practitioner group about the challenges and barriers to professionals working with 'curiosity. There was a suggestion that capacity to be 'curious' was dependent on work pressures and workloads and to some extent, professional knowledge, and specific concerns about a child and/or their situation.

7.5.15. Laura, the review team was reminded, was a child about whom there were no significant concerns and who presented behavioural difficulties only for her mother and only at home. Even accepting that children can behave differently in different settings, it would be expected that there would have been more curiosity about Laura's behaviour when she was at home and perhaps more dialogue between professionals in health and education settings - working in partnership does enhance the likelihood that professional curiosity will flourish.

7.5.16. There were references in all agency records to ML's struggles with Laura's behaviour at home, the fact she presented at school as lively, talkative and well behaved was attributed to the structure and boundaries of classroom settings which were thought not to be in place at home. There was perhaps an unstated assumption that Laura's behaviour emerged from her mother's parenting style and there was evidence of little curiosity or attempts to explore other possibilities. It is important to state that support to Laura and the family by SCH3 was good and it is only with hindsight that questions are now being asked about what might have alerted professionals to the need to question more deeply about what might be happening at home. Practitioners told the review team that it can be difficult, at times for schools to determine how far they should go when challenging parents or questioning what is happening in families. In Laura's situation, as she grew older although SCH3 noticed changes in family dynamics, they did not have evidence to warrant a referral to CSC, but neither were they sure of how far they could go in exploring family relationships.

7.5.17. Unlike health and colleagues in children's services, school leaders do not have access to an education 'safeguarding lead'. Without access to opportunities, available in other disciplines to reflect on their thinking and make decisions about the best way forward, professionals in education, despite being well-placed to do so, may be less likely to challenge things with parents that 'do not seem quite right' especially when the child themselves appears to be fine.

Finding 4: *There are risks of professionals making assumptions and taking things at face value without enquiring more deeply into what might be happening in the home environment. Professionals who are questioning and curious create opportunities for opening up conversations with people to explore vulnerabilities, seek their views, and understand their needs, but without access to supervision and opportunities for reflection professionals with busy workloads may be less likely to be curious about those children about whom they have no significant concerns.*

This was a finding that resonated with practitioners and the review team and going forward, continues to have implications for practice in Newcastle in 2020.

7.6. **The 'invisible' male in Laura's life**

7.6.1. Men play a very important role in children's lives and have a great influence on the children they care for or with whom they are in regular contact. Despite this, research and SCRs suggest men are too often ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers and female carers.

7.6.2. Professionals relied solely on information from ML and Laura about BML. The review team could find no significant information about him in any agency records, yet he was a significant member of the family for over 7 years. There is no description of him as an individual or any reference as to how ML and BML met, where he lived, who his family were, and whether ML's own family had contact with him.

7.6.3. In Laura's medical records, there were only very occasional references to him as 'dad' or 'stepdad' or even just his first name but there was no any additional information to confirm his status and relationship to Laura. A letter from CP2 after Laura attended a hospital appointment was addressed to the '*Parents of Laura'* and one paragraph directed specifically to BML read '. *BML, you told me that Laura is getting more independent… with the support you are providing to the family, although you think she had better concentration when she was on medication*'. With hindsight, this letter and its contents offer a sobering picture of the role BML played in Laura's life. Although, significant, he nevertheless remained a background figure about whom very little was known.

7.6.4. A repeated finding in national case reviews is how often fathers and male figures are absent in recordings, children's assessments and care plans. Reviews have highlighted recurrent shortcomings and pointed towards the failure of many social workers and health professionals to engage with men whose involvement with mothers is evident even though they may appear on the periphery of family life. The review team was of the view that when protecting and supporting children, practitioners need to proactively assess and where possible engage with all significant men in a child's life, understanding that some may pose risks, some may be assets to the family, and some may incorporate aspects of both.

7.6.5. However, exploring personal relationships within families can be challenging. Practitioners must balance their safeguarding duties with respect for confidentiality and for an adult's personal autonomy to choose with whom they want to spend their time. Practitioners depend to a significant degree on what individuals choose or can disclose and this is shaped by the awareness, perception, and candour of the individual concerned. Some parents may be unaware of a partner's background, deny its significance, or be unable or unwilling to share information with professionals.

7.6.6. It is however, essential that professionals who work directly with children are aware of the significant people in their day-to-day lives for three specific reasons: firstly, where there are known and perceived vulnerabilities in a child, professionals must be mindful and aware of particular risk factors which increase a child's vulnerability to abuse; secondly the risk of abuse is known to be higher with stepfathers or parents' partners than for example with biological fathers and lastly, family dynamics and relationships impact on a child's emotional development and their ability to learn and

flourish, so professional understanding of who is who in a family and who does what, is crucial to understanding the child's lived experiences.

7.6.7. Professionals need to make careful judgements about when to actively seek information about family members and the personal relationships of adults with whom children are in contact. Even where no concerns are present, it is legitimate and entirely appropriate for professionals in all agencies to ensure they know who lives in the family and what relationship they have with the child.

7.6.8. This issue was discussed in some depth with professionals and whilst the importance of finding out more about who lives with and/or has significant contact with children was acknowledged, the practicalities of acquiring and maintaining that information was thought to be problematic. Yet, BML appears to have been conveniently invisible to all the professionals who knew Laura, and this allowed him to continue his abuse with impunity.

7.6.9. From 2010 until 2017, Laura attended her GP surgery on numerous occasions for various ailments usually related to ear, nose, and throat problems. Until 2013, Laura was taken to these and other appointments by her mum and very occasionally by her support worker. From 2013, however, that BML occasionally began to accompany ML and Laura to some of these appointments, there is a suggestion that BML may have accompanied Laura to GP visits by himself, but this information was difficult to verify as medical practitioners rarely made a note of who attended with Laura on these visits.

7.6.10. Only in 11 of the 69 consultations, did the medical notes specify who accompanied Laura on her visits to the GP surgery. Where references are made, they refer to 'mother' 'father' or 'parents'. On three occasions the notes refer to 'Dad' when in fact Laura had no contact with her biological father. There appears to have been very little interest in this individual by any professional and to what extent he contributed to Laura's care and well-being. Professionals in SCH3 told the review team that ML was very open about her relationship with BML and Laura, until she was an older adolescent, usually referred to him without any reluctance or hesitancy and this may well have influenced their perception of his role in the family.

7.6.11. There was, however, no information recorded in any agency files about BML, although he had lived with the family for over 7 years. Practitioners acknowledged to the review team, there can be a reluctance to ask or seek information about males who are living in the family and/or who may be significant figures in a child's life and asking about the status of key relationships can be seen as intrusive. However, this ignores the risks that might be posed to children by men who deliberately and purposefully target vulnerable children, such as BML.[24]'.

Finding 5: If professionals in contact with children do not regularly update their records about family members and purposefully and intentionally seek out

[24] *Hidden men: learning from case reviews. NSPCC April 2015*

information about significant males in a child's life, the risks posed by some men are more likely to go unrecognised.

This was a finding that resonated with practitioners and the review team and going forward, continues to have implications for practice in Newcastle in 2020.

7.7. Professional knowledge and understanding about familial sexual abuse and the modus operandi of perpetrators

7.7.1. In July 2014, the Children's Commissioner launched an Inquiry into child sexual abuse in the family environment. The data examined by the Commissioner suggests that only 1 in 8 victims of sexual abuse come to the attention of the police and children's services and up to two thirds of all sexual abuse happens within a familial context.

7.7.2. Much of the research available shows that children in families are sexually abused from a young age, and yet most victims do not come to the attention of the police or children's services until they reach adolescence. Even then, accessing help from the police and children's services is largely dependent on a child telling someone that they have been abused, but research clearly highlights that most victims of sexual abuse in the family do not report it until they have the knowledge to recognise abuse and the words to describe it and/or there is sensitive outreach by a trusted adult.

7.7.3. There are many reasons why Laura could not or would not tell anyone about what happened to her and without Laura's help, professionals can only guess at what those reasons might be, certainly the reasons for her non-disclosure in her mid-teens may well be different to why she did not tell as a younger child.

7.7.4. The specific difficulties for disabled children disclosing abuse are well known.[25] Research tells us that abuse of disabled children often takes place over several years and disclosures, where they do occur, are often made several years after the abuse began. Triggers for disclosure include a growing awareness of the abusive nature of their experiences, increased severity of the abuse and family conflicts. Studies also indicate that disabled children are more likely to delay disclosure of abuse than non-disabled children because of a lack of awareness of the abusive nature of their experience, fear of the consequences of disclosure, difficulties communicating the experience in a coherent way and importantly, a physical and psychological reliance on their abuser for care in the family.

7.7.5. Research has found that a significant proportion of perpetrators who sexually abuse children in a familial setting utilise what are known as "grooming" behaviours. These are behaviours which perpetrators use to gain access to a vulnerable child, gain their trust and compliance so they can maintain the child's secrecy and avoid disclosure. Sex offenders are skilled in grooming not only the child but also the family, the community and even professionals so that sexual abuse can be more easily committed without detection.

7.7.6. Despite Laura being in close and regular contact with medical and school staff, it remains likely that her abuse would never have been detected had the police not

[25] *We have the right to be safe' Protecting disabled children from abuse. NSPCC 2014*

learnt of BML's involvement with her family. Professionals told the review team they never considered the possibility of sexual abuse. Yet, knowing how perpetrators work and understanding that children with disabilities are at a much higher risk of abuse than non-disabled children, Laura's presentation and behaviours should have sparked greater professional curiosity both during the times concerns were reported to CSC and upon listening to ML and Laura talk about their home life.

7.7.7. ML was not a working mother so BML would have had to create opportunities to be alone with Laura and to ensure that his abuse would not be discovered. The review team were mindful of the neighbour's comment in Area2 that he often turned up at his house every few days '*with a young female'*. Having his own accommodation would have made his abuse of Laura very easy with very little chance of detection. The sessions provided by SCH3 about keeping safe would appear to have provided Laura with many opportunities to talk about what was happening. It may have also been helpful if professionals had sought to find out a little more from Laura herself in one to one sessions about her 'behaviours' at home and what triggered these. The review team was of the view that Laura's voice was too often heard through that of her mother's.

7.7.8. Key questions for practitioners during the review process were '*did ML know or suspect'* and '*how could she have not known*? There was certainly no evidence to suggest that ML knew of the abuse or colluded with BML. What did emerge during the review process was an acknowledgement that ML herself was likely 'groomed', by BML, as were professionals, into believing that he was a safe and nurturing adult to be around her daughter.

7.7.9. The modus operandi of perpetrators needs to be well understood by professionals because the kinds of behaviours typically employed prior to the commission of these offences are the kinds of behaviours that would normally indicate positive parenting. In this sense, it can be very difficult to identify important warning signs for adults who care for non-related children. Nevertheless, professionals should be aware of the common tactics of offenders to seek any opportunities to have time alone with their victim, and to ingratiate themselves with their victim's parent and any other adults around the child, including professionals.

7.7.10. Victims of sexual abuse rarely tell teachers or other professionals about what is happening directly, it is more likely that suspicions will be raised by the behaviour or presentation of a child or young person. This is the 'grey' area, and professionals are called upon to act on their judgement in the best interests of the child. As with any type of abuse, there is an overreliance on children to come to statutory services to disclose abuse happening to them, but given that only 1 in 8[26] children known to experience sexual abuse, come to the attention of statutory authorities, the focus has to remain on professionals being attuned to changes in behaviour of children, their emotional responses and other indicators that things are not going well in their lives.

7.7.11. Before any careful and sensitive outreach towards a child can take place, professionals must first consider several hypotheses which might explain a child's behaviour and sexual abuse should be considered as one possibility amongst many

[26] *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England Children's Commissioner. November 2015*

even though it may be discounted then or later. In Laura's situation, this appears not to have happened and there is some evidence to suggest a primary focus on disability may have obscured the need by professionals to '*think the unthinkable*'. There cannot be definitive lists of how abuse will be manifest by children of different ages, disabilities, and personalities. What is needed is careful vigilance by professionals coupled with a commitment to provide children with disabilities with '*permission*' to tell responsible adults if anyone acts inappropriately around them and to provide disabled young people with information that will allow them to enter into age-appropriate sexual relationships from a position of confidence. The review team was told that these opportunities were certainly afforded to Laura by experienced staff in SCH3 who were confident that their approach was sensitive, non-judgemental and empowering.

7.7.12. Laura's alleged difficult behaviours at home could have been as a result of several factors including the way she was parented, adverse experiences as she was growing up or possibly Laura's frustration at not being able to clearly communicate her wishes and feelings. Equally, Laura's alleged behaviours at home could have been a confused response to the sexual abuse perpetrated abuse by BML. The review team was of the view that Laura's behaviours did not generate enough professional curiosity, for any of the professionals working with the family. Had this not been the case, perhaps professionals might then have felt it necessary to look for explanations to develop a better understanding of what was going on for Laura.

7.7.13. The dynamics of child sexual abuse differ from those of adult sexual abuse, children very rarely disclose sexual abuse immediately after the event. Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour. Research[27] suggests that most victims go unidentified because protective services are geared towards children self-referring or reporting abuse, although they rarely do this. Often, children may not even recognise, perhaps like Laura that they have been abused.

7.7.14. This review has highlighted that although practitioners were knowledgeable about familial sexual abuse - and many practitioners had worked or were working with families where this was a significant concern - there was still a reluctance by some professionals to consider sexual abuse where behavioural concerns about a child had been raised, because, practitioners told the review group, there could be many possibilities to account for children's behavioural problems. Research[28] suggests that many professionals can, understandably and without proper guidance, be hesitant to seek information or clarification from a child for fear that such actions will be construed as 'leading the victim' and placing ideas in their head.

7.7.15. Professionals will come into contact with children who are victims of familial sexual abuse and yet may never become aware of what is happening or what has happened. For other children, there are often some signs or indicators, that *'something is happening'* though exactly what, may not be obvious or conclusive. The identification of child sexual abuse is a considerable challenge to professionals and evidence examined by the Children's Commissioners suggests that child sexual abuse in the family environment will often come to the attention of statutory and non-

[27] *Protecting Children from Harm Children's Commissioners 2015*
[28] *ibid*

statutory agencies as a result of a secondary presenting factor but unless there is an awareness and willingness to consider sexual abuse, it is the presenting factor which can too easily become the sole focus of professional intervention.

7.7.16. There were many explanations, which could have accounted for Laura's 'difficult' behaviours although concerns never met the threshold for statutory intervention. The possibility of familial sexual abuse was however never considered, even given the ways in which the impacts of disability can mediate or set the scene for a child's increased vulnerability to this form of abuse.

***Finding 6**: Unless there is a disclosure or the presence of easily recognisable signs and symptoms, professionals may not always consider the possibility of child sexual abuse as often as they should do, and this can leave some children vulnerable*

This was a finding that resonated with the review team and continues to have implications for practice in Newcastle in 2020.

8. Concluding comments

8.1. Undertaking a serious case review spanning six years carries its own challenges, not least of which is that policies and practice change in line with emerging knowledge about what is known to work well. It would be unusual if in the period under review there had been no changes in how agencies work singularly and in partnership to safeguard and protect children. The review team was acutely aware of the dangers of examining practice 'then' against the standards and systems in place today. Nevertheless, conversations with all those involved in the SCR process indicate that the lessons emerging from this review remain as relevant today as they were several years ago.

8.2. One of the continuing challenges facing professionals called upon to contribute to serious case reviews or enquiries is being aware how knowledge of an adverse outcome for a child influences thinking about what should have happened to prevent that outcome. Knowing now what happened to Laura during the years, BML lived in the family, it is difficult not to ask why professionals did not consider the possibility that her vulnerabilities and her reported difficult behaviours could be linked to abuse or that the presence of a non-biological male in the family increased the likelihood that she was at risk.

8.3. Some of the key opportunities presented to professionals working with disabled children and their families lie in their recognition and understanding of the heightened vulnerability of these children and the potential interaction with risks and harms. The learning emerging from this SCR highlights the importance of professionals being continually mindful that risks to all children and especially those with additional vulnerabilities, are ever- present requiring them to be ever- vigilant and ever-curious.

9. Summary of Findings

***Finding 1:** Laura's learning difficulties were well understood, but not all professionals demonstrated an awareness that Laura was at heightened risk of sexual abuse in her family. A lack of awareness about sexual abuse of children with disabilities among professionals contributes to their vulnerability.*

Finding 2: *Professionals coping with multiple demands in stressful work environments need access to support and regular reflective supervision. Without this, errors are more likely to occur this can leave children vulnerable.*

Finding 3: *Professional understanding about the lives and experiences of children with disabilities can impact on all aspects of a child's life. Unchecked assumptions can inhibit professionals from focusing on the child and family and this limits communication and exploration about what may be happening for a child in their family.*

Finding 4: *There are risks of professionals making assumptions and taking things at face value without enquiring more deeply into what might be happening in the home environment. Professionals who are questioning and curious create opportunities for opening up conversations with people to explore vulnerabilities, seek their views, and understand their needs, but without access to supervision and opportunities for reflection professionals with busy workloads may be less likely to be curious about those children about whom they have no significant concerns.*

Finding 5: *If professionals in contact with children do not regularly update their records about family members and purposefully and intentionally seek out information about significant males in a child's life, the risks posed by some men are more likely to go unrecognised.*

Finding 6*: Unless there is a disclosure or the presence of easily recognisable signs and symptoms, professionals may not always consider the possibility of child sexual abuse as often as they should do, and this can leave some children vulnerable.*

10. Recommendations in response to Findings

Recommendation 1: *All Findings:*
In the light of findings from this review and those identified in the Children's Commissioner report in 2015[29]*, the partnership should consider whether there is a need for an authority wide, multi-disciplinary strategy for the prevention, identification, and response to Familial Child Sexual Abuse in Newcastle*

Recommendation 2: *Findings 1, 3 and 6*
The partnership needs to evidence how it is assured that professionals in all agencies are well equipped to recognise and understand that concerns about the behaviour, health, well-being or safety of children with disabilities may be attributable to familial sexual abuse, even if this hypothesis is later discounted.

Recommendation 3: *Findings 2, 4 and 5*
The partnership needs to evidence how it is assured by senior managers in key agencies that effective systems are in place for staff to have formal opportunities for reflection and supervision, so cultures of support and challenge develop. Consideration should also be given as to how schools can be better supported and/or challenged about their management of what they might view as low level concerns.

[29] *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England Children's Commissioner. November 2015*

Recommendation 4: *Finding 5*

The partnership needs to evidence how it is assured that regardless of an adult's status, if they have parental responsibility or not, if they are resident in the home or not, their involvement and relationship with the child is always explored and considered and professionals retain professional curiosity and talk to children and young people and the adults in their life

Recommendation 5: *Single Agency Findings*

The partnership should ensure that those agencies who have contributed to this SCR have in place action plans in response to identified learning and these plans are monitored in terms of their effectiveness and impact on improved outcomes for children.

Appendix A - Single agency learning identified in agency learning reports

Health: NHS Foundation Trusts (FT1 and FT2)

None identified

CCG/GP Practice

- There was no meaningful consistency of recording of who attended medical appointments with Laura. As previously stated, this is important for children but there is additional significance when the child has a learning difficulty.
- Recording of consultations were brief therefore it was difficult from what was written to visualise Laura and have a clear picture of her presentation. There is no evidence in her records that her views were sought or recorded and there is no documented evidence that she was offered the opportunity to be spoken to alone.
- A Cardiff Health check was completed which is a medically orientated checklist and there was no evidence in the records that Laura's sexual activity or any associated risks was explored or, how the collated information was used to support Laura. The National template for annual health checks for children with a learning disability was revised in 2017 and now includes a question specifically asking about the risks of sexual abuse and sexual exploitation.

  All these issues have been discussed with the practice involved and an action plan developed. The findings from this review will be shared on a wider basis with practices across the region to address the identified learning.

Education: SCH2, SCH3

None identified.

Children's Social Care (CSC)

- Managerial oversight and supervision of cases is now regularly quality assured through audit and performance management
- Importance of MASH and continued audit of threshold application/decision making at the Front Door.
- Continued commitment to staff health and wellbeing series and focus on supervision across the service as a key component of safe and stable practice.
- Opportunities to offer further training and resource to practitioners in exploring the lived experiences and world of children living with mild to profound learning difficulties and disabilities
- Recognising the benefits of practitioners having access to tools and resources to support them in their work, a Participation Toolkit for practitioners has recently been

launched. This includes a software application - MOMO – to help children share their views and experiences with the professionals working with them. The app includes a strand, which is specifically designed for children and young people with learning needs, difficulties, or disability.

Northumbria Police

- A more robust investigation into BML should have been conducted. However, changes in the way sexual and violent offender in the community are now managed have strengthened arrangements.

- It is recognised there is an administrative impact on the implementation of the Operational Team Risk Management Officers who have warranted powers. These tasks significantly reduce their ability to effectively manage Very High and High-risk offenders living in the community. In doing so it has an effect of increasing stress on those officers who are required to provide a greater degree of management on their RSO's due to their degree of risk. This element of the model has echoes of the processes within MOSOVO prior to the implementation of the working model.

- Managers within the workplace have recognised this and 3 administrative support staff have been employed with a further 2 to be brought into the unit with a view to removing non-warranted administrative tasks. By removing this burden, it will allow officers to proactively manage higher risk Registered Sex Offenders and reduce their opportunities to commit further offences and eliminate the non-identification of increased risk factors.

Appendix B – List of agencies involved

NHS Newcastle Gateshead Clinical Commissioning Group
Northumberland Tyne and Wear NHS Foundation Trust
Newcastle upon Tyne Hospitals NHS Foundation Trust
Northumbria Police Force
Newcastle Adult Social Care
Newcastle Children's Social Care
Newcastle Schools and Learning