# Oldham Thematic Child Safeguarding Practice Review

## Child Q and Child R

Report for publication

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Contents Page

# 1. Analysis of the key themes

## 1.1 Introduction

1.1.1 The following sections will analyse the key themes identified by the review panel listed below:

- How do we initiate preventative strategies to manage children with additional needs who are exhibiting risky behaviour or whom are beyond parental control? Consider this for those at risk of Child Sexual Exploitation (CSE) and whether the current tools and processes around CSE take sufficient account of this cohorts' extra vulnerabilities
- Consider the consistency of response and application of thresholds to children with additional needs exhibiting risky behaviours or thought to be at risk of harm. How do the systems operate when the issues become increasingly challenging?
- Do our services respond fully and consistently to the presenting issues across all cultures and social circumstances? Consider adoption, attachment issues, parental learning needs
- How do we make use of the current framework of policies, procedures and systems to coordinate and manage complex and challenging cases? Who gets missed? Consider funding pathways, resources available, budgeting pressures within each agency, is this leading to earlier interventions not being actioned?
- How do we plan transition of complex case within children's services and between children's and adult services?
- Was the voice of the child captured? How is this different for children with additional needs e.g. Special Educational Needs and Disabilities (SEND), Learning Disability, Autism, Attention Deficit Hyperactivity Disorder (ADHD)? Can we see this was acknowledged with changes in practice to reflect this? Is there evidence of consideration of children's right v parental rights as the subjects moved towards adulthood?
- Do current policies, procedures, systems and practice support children with additional learning needs to receive education in the most appropriate way? Consider children excluded from education and home schooling.
- Is the current response to children with additional learning needs who go missing taking sufficient account of their extra vulnerability?
- How did we manage, recognise and respond to the potential of a forced marriage?
- What support was/is there for Parents following diagnosis for Disability issues, e.g.; ADHD, Autism Spectrum Disorder (ASD) etc.
- Giving consideration to the transforming care agenda for those with people with a learning disability and/or autism who display behaviour that challenges, have we been able to commission specialist services effectively?
- Does the process around child protection conferences ensure parents are fully aware of the nature of the meetings and concerns of professionals before they attend?

## 1.2 Working with risk in the context of Child Sexual Exploitation and additional needs.

1.2.1 This section will explore how Oldham's agencies initiate preventative strategies to manage children with additional needs who are exhibiting risky behaviour or whom are beyond parental control. It will consider this for those at risk of CSE and whether the current tools and processes around CSE take sufficient account of this cohorts' extra vulnerabilities.

1.2.2 Both the children within this review are deemed Children in Need, as defined by the Children Act 1989, due to their mental disorders. As such it was highly probable, they would need additional support from services as they developed. Both children were attending a special school for children with Autistic Spectrum Disorder (ASD).

1.2.3 Several studies have reported that developmentally disordered children are vulnerable to sexual victimisation. Autistic people may be at higher risk of being abused than other people. It can also be more difficult to detect they are being abused. This may be because autistic people can have limited speech, struggle to communicate and find it difficult to identify their emotions. They may also demonstrate that they are being abused by a change in behaviour[1].

1.2.4 It is therefore vital that children who have conditions which increase their vulnerability to exploitation and harm receive preventative interventions as a routine. All children with ADHD and ASD are at increased risk and so it is vital that CSE services work closely with education to develop and deliver specialised preventative programs for this vulnerable group. The sexual health education the children in this review received was focussed on changes at puberty rather than strategies for keeping them safe. The Safeguarding Board's Children & Young Persons Training Officer delivered an e-safety session to pupils at the school in 17 March 2017, and to parents at the school in the same month however the review is not clear whether the subjects of this review and their parents attended. The reviewer learned that a decision not to prosecute an abuser in one of these cases, was based on the fact the young person would not make a credible witness. Unless there is wider thinking and ways are found to address this, children with additional needs will always be disadvantaged within the legal system.

1.2.5 Schools are in a good position to promote healthy relationships and make sure children and young people know who to talk to if they ever need support. Keeping Our Girls Safe (KOGS)[2], a resource designed to prevent CSE, is available within Oldham's schools. However, there is recognition across the partnership that the preventative work around CSE is under resourced. From September 2020 a specialist school health practitioner will be providing health related information within drop-in sessions providing an opportunity to cover preventative strategies which is welcome but is unlikely to reach all the children.

1.2.6 The NSPCC have developed some tips for promoting healthy relationships for children and young people with SEND[3]. These are:

- Follow children and young people's support plans to ensure you're meeting their individual needs.
- Work with parents and carers to make sure they are comfortable with the discussions you're having and know how to talk about healthy relationships at home.

[1] https://www.autism.org.uk/professionals/health-workers/safeguarding.aspx
[2] https://www.kogs.org.uk
[3] https://www.learning.nspcc.org.uk/safeguarding-child-protection-schools/promoting-healthy-relationships

- Use a range of methods such as books, stories, drama, audio-visual material and role play to help keep regular messaging fresh.
- Emotion boards or charts may help children with SEND express how some relationships make them feel.

1.2.7 Parents play a vital role in protecting their children from CSE and need empowering to do so. They are often the first to identify signs that something is wrong with their child.[4] It is essential that practitioners ensure parents receive information on the early warning signs of CSE so if these signs appear, parents can then share information with the police, which can help to identify perpetrators and be successful in prosecuting them. It's also essential for agencies and specialist organisations to provide non-judgemental support to parents - to listen, understand, respect and value the contributions parents can make in safeguarding their child; this was not the reported experience of one of the families.

1.2.8 It is evident that the parents in each of these cases were seen as part of the problem, one child being termed "beyond parental control"; her emotional dysregulation being viewed in the context of boundaries and parenting with little consideration of her autism and the attachment issues this brings. In both cases there was a lack of understanding of the children's lived experiences and a lack of consideration of their behaviours in the context of their diagnoses, suggesting a lack of understanding of autism and ADHD. Descriptive language such as "problematic violent behaviours" "refusal to attend school" "choosing not to communicate with others" "flirtatious" appears to be suggesting the children were making active choices rather than experiencing difficulties.

1.2.9 Interventions that were offered were not adapted to take account of their individual needs. Within the Children's Social Care (CSC) learning summary, the author has highlighted a concern regarding the language used. The reviewer has had an opportunity to speak with one family who confirmed that the CSC response to the children and parents, inhibited collaborative working, so essential in such cases. The evidence in these cases shows fractured relationships between the parents and some of the professionals (see section re parent child violence), which proved unhelpful in preventative work.

1.2.10 What is apparent is that when CSC were first contacted about each case during the review period, the threshold was reached for both cases to warrant child in need (CIN) plans. The failure to move into CIN was due to different reasons. In one case the decision by Multi Agency Safeguarding Hub (MASH) that a single assessment was needed was de-escalated to a short break assessment, the rationale for this decision is not fully understood. The initial triage by MASH was completed on a multi-agency basis however the decision within the children with disabilities service was taken on a single agency basis with no further consultation with partners, thus reducing the potential for challenge. In the other case neither a CSE assessment or the social worker assessment, both of which identified needs and risks, lead to development of a multi-agency CIN plan for 10 months. Thus, in both cases, opportunities to understand the concerns and introduce preventative strategies to reduce the risks to the children, were missed. Parents indicated there was an absence of 1:1 work with the child and multiple changes in workers proved problematic in building relationships and trust.

[4] Parents against child sexual exploitation (2016) Supporting parents and carers of children and young people affected by sexual exploitation: A toolkit for professionals

1.2.11 It appears that at that time, there was lack of decision making and managerial oversight. The systems in place were not assisting managers to ensure statutory processes were taking place in a timely manner; these are now in place.

**Learning point:** Working with children with a range of different conditions requires a high level of understanding of those condition by practitioners. Whilst frontline professionals whose whole work is with children who are autistic or who have ADHD, have the knowledge and skills, this is not evidenced in practitioners working with a wide range of disabilities and in their managers. It is also problematic for services whose normal ways of working are impeded by the child's condition. Lack of progression to prosecution in one case is reported to have been attributed to three factors, lack of credibility as a witness, whether this was a consensual act and the poor command of the English language of the alleged perpetrator.
CIN is a statutory process designed to co-ordinate a multi-agency approach to offer support and services to those in need. Decisions to de-escalate cases before a full holistic assessment of support needs has been completed, in children who have additional needs, is reducing the opportunity to intervene early and prevent harm and abuse. When a multi-agency decision is made that an assessment is required this should not be overturned without consultation with partner agencies and with a clear rationale for the decision. Services are currently designed to work for the majority of children. However, children with additional needs may require a bespoke service that is sensitive and appropriate to meet their needs or for the service to be sufficiently flexible to allow a tailored approach. Oldham now has a Complex Safeguarding Team working within a hub where partner agencies are working together to provide Early Help, preventative support and problem solve complex cases to establish the best type of intervention or course of action for a family or individual, at the earliest opportunity.

**Recommendation:** Oldham Local Safeguarding Children Partnership (LSCP) and its partners to seek assurance that the new ways of working are taking sufficient account of the additional complexity working with children with additional needs brings and that based on their learning, the young person is able to make changes that offer greater protection.

**Recommendation:** Oldham LSCP to alert the National Panel that viewing children with additional needs as not able to make credible witnesses, is preventing the possibility of prosecuting offenders who are targeting our most vulnerable children.

**Recommendation:** Oldham LSCP and its partners to explore whether children with additional needs, who make allegations of abuse, are underrepresented in cases progressing to prosecution, solely based on their credibility.

**Learning point:** Current preventative provision for children with additional needs is not sufficient and leaves this already vulnerable group susceptible to exploitation. Services are not collaborating with families to provide a consistent approach to keeping these young people safe.

**Recommendation:** Oldham LSCP to work with its partners to ensure a more collaborative approach is taken, when working with families with a child who has additional needs who is exhibiting risky behaviours.

## 1.3 Application of thresholds, escalation and de-escalation across the continuum of need.

1.3.1 This section will consider the consistency of response and application of thresholds to children with additional needs exhibiting risky behaviours or thought to be at risk of harm, and how operate when the issues become increasingly challenging.

1.3.2 There was an inconsistent response to referrals made when the children were exhibiting risky behaviours with one child receiving an intervention and the other not. The referral regarding Child Q resulted in a strategy meeting being held and a multi-agency approach, whilst the referral regarding Child R was deemed not to meet the threshold for a strategy meeting. This decision was not challenged. It seems aspects of the families may well have impacted. Child Q's parents were better able to articulate their thoughts, feelings and needs. Child R's mother was not. Child R was from an Asian background and it is possible that this led to an unconscious bias, although there is no evidence of overt racism.

1.3.3 Practitioners indicated they had experienced confusion as to why some referrals go through and others do not. This is currently being addressed through Training Officers and CSC are carrying out work to address this.

1.3.4 Once the risky behaviours were recognised as such, whilst there was significant information sharing between agencies, there was no co-ordinated multi-agency approach or plan to either solve the problems or recognise when the cases needed to be escalated. As a result, the parents were left to manage very risky situations, relying on the police to attend when they were being assaulted or the children went missing.

1.3.5 Assessments completed, do not demonstrate a depth of understanding of the complex issues apparent in these cases. Whilst CAMHS's were involved and provided information within meetings, this did not have the effect of guiding those with a lesser understanding, to working with the subjects in a way that they could begin to understand the world from the subject's perspective based on a psychological formulation. It appears that in one case, attachment issues in infancy which had been addressed, continued to form the basis of practitioners thinking, without full consideration of changes over intervening years. Whilst all professionals are urged to consider the history of the family within assessments, they need to be sure that past concerns are not overshadowing current concerns.

1.3.6 There is evidence that some services increased the frequency of appointments offered and the Early Help Intensive Support Team increased its level of intervention when they were involved. Whilst additional hours of respite care were offered it is difficult to demonstrate whether this resulted in any positive effect for either the children or the parents. Practitioners indicated they struggled with referrals for Short Breaks. The courts have ruled that whilst parents are entitled to an assessment, they are not entitled to a short breaks' assessment; this decision has impacted both parents and practitioners who are unaware of the court judgment. The local offer for support to young people with autism is limited. It includes Autism Youth Clubs, but these can be oversubscribed, or teenagers do not want to attend and there are gaps for other age groups; they are not always appropriate for every child.

1.3.7 The school raised their concerns that they were not able to meet the subjects needs on a number of occasions. This was often met with a response that they were a specialist school and it was for the school to address. This was most unhelpful, and focus was lost on the young person's needs. Those with the power to decide an alternate placement were also of the opinion that the school should be able to meet

the children's needs as they were a specialist school for children with ASD. The focus was on the subject's diagnosis and not on their primary needs. What managers were not considering was the additional therapeutic needs of the subjects.

1.3.8 Working with complex cases is hugely challenging and requires input from highly trained and experienced professionals. The professionals working with the subjects required, and should have expected, support from those in senior positions. There is some evidence of support however, there was an expectation that a commissioned service would, in all circumstances, be able to meet the needs of their cohort; this will never be the case. Always when a combination of complex issues develops there will be cases that require a bespoke intervention.

1.3.9 Eaton and Holmes[5] in a scoping review of safeguarding practice with children who are sexually exploited developed six key principles:

1. Young people must be at the centre and should not be held responsible for their harm or their safety.
2. CSE is complex; therefore, the response cannot be simple or linear. Responses need to be based on evidence from a wide range of sources of expertise.
3. No agency can address CSE in isolation; collaboration is essential.
4. Knowledge is crucial.
5. Communities and families are valuable assets and are likely to need support.
6. Effective services require resilient and supported practitioners.

These principles indicate the need for robust multi-agency and community collaboration to support adolescents and share relevant information. The complex nature of CSE requires services to provide on-going support which is flexible enough to respond to crisis.

**Learning point:** Consistent application of thresholds is an issue that arises from a significant number of safeguarding children reviews. Whilst this was clearly an issue in this review, the newly developed Complex Safeguarding Team is well placed to address this issue and bring about a more consistent application of thresholds.

**Recommendation:** Oldham LSCP to seek assurance that the change of working with MASH and introduction of the Complex Safeguarding Team has addressed the inconsistencies in the application of thresholds.

## 1.4 Do our services respond fully and consistently to the presenting issues across all cultures and social circumstances? Consider adoption, attachment issues, parental learning needs.

1.4.1 This review suggests that the response to families of different cultures and social circumstances is inconsistent. Child Q is of Asian background with White British adoptive parents and Child R from a Pakistani background. The response to the two children and families was markedly different indicating potentially culturally biased practice. There were additional differences between the two families, Child Q's parents were seen as intelligent and articulate and would challenge professionals. In contrast Child R's mother was thought to have some learning and communication

[5] Eaton, J. and Holmes, D. (2017) Working effectively to address Child Sexual Exploitation: An Evidence Scope. Available at: https://www.rip.org.uk/resources/publications/evidence-scopes/working-effectively-to-address-child-sexual-exploitation-evidence-scope-2017-

difficulties and seemed more accepting of her situation. Whilst services were generally aware of mothers' difficulties there is limited evidence that this influenced the way professionals practised or was considered when services were deciding what actions to take. There is evidence of much greater action following referrals for Child Q than Child R.

1.4.2 Within records it was noted that from an early age there were attachment issues between Child Q and her mother and that both Child Q's parents had very different parenting styles. Parents indicate this is not correct. Child Q's parents report they sought assistance around attachment as although Child Q was attached to both of them, because of earlier adverse childhood experience pre-adoption, Child Q was constantly seeking a safe place.

1.4.3 CAMHS had extensive involvement for a number of years. Despite displaying some challenging behaviours Child Q was not diagnosed with ADHD and autism until the age of 14. When Child Q's behaviour deteriorated professionals were right to consider that this may be as a result of insecure attachments, but this should have been considered within the context of the behaviours being displayed.

1.4.4 A recent study found that violence and abuse was an issue in as many as 30% of adoptive families[6]. CSC assessment appears to have been overly focussed on the attachment issues and this led to great difficulties (see section 3.13 re Child Protection Conferences).

1.4.5 Child parent violence is thought to be an increasingly common phenomenon, but it is not new. There is a tendency for professionals to view parents negatively and think they have not set sufficient boundaries, even in families with other children who are not displaying the same behaviours, who have been parented the same way. Fear of being blamed acts as a barrier to parents requesting help until the situation is desperate; indeed, they may not identify the problem as abusive themselves until this point. There is currently an absence of research but reports that we do have and anecdotal testimony from services, suggests that as many as 10% of families with teenagers may experience violence and aggression at "beyond normal" rates and that for around 3% families, this might be extreme and dangerous.[7] The impact of child to parent violence can be catastrophic. The Office for National Statistics has shown that in the year ending March 2017 there were 11 recorded parricides.

1.4.6 Child to parent violence appears to affect all levels of society. Although many parents reporting this form of violence to the police are not in full-time employment and some are struggling with financial and housing problems; others are in professional jobs earning high incomes[8]. Child to parent violence has been seen to be associated with, amongst other things, early trauma, learning disability, neurodiversity, later loss, poor mental health, poor physical health, parental difficulties, and the experience of witnessing domestic violence. When we understand behaviour as communication, we start to see the need to build understanding and support structures early on, around childhood difficulties and around whole family systems.

1.4.7 In a study by Condry she indicated that the current child protection system is geared up for parent on child abuse, not the other way round," she says. "This is seen as a 'parenting' issue with the child not being seen as being at risk from the parent. We

[6] https://www.government/publications/beyond-the-adoption-order-challenges-intervention-disruption

[7] https://www.mentalhealthtoday.co.uk/innovations/why-child-to-parent-violence-is-an-overlooked-challenge

[8] Home Office Information guide: adolescent to parent violence https://www.assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf

have to expend a lot of energy in making the case to achieve support for child on parent abuse cases." Condry is also clear that seeing child to parent violence as a parenting issue is an over-simplification. "I am really reluctant to dwell on explanations that involve blaming parents," she says. "There are so many complexities in families that this happens to. "It's impossible to work with this by adjusting your behaviour, filling out a worksheet or trying to lay down boundaries," she says. "That sort of thing is not going to work if someone has lived under siege for a couple of years."[9]

1.4.8 Child Q's parents approached services asking for help which they did not receive; the parents of both subjects received limited additional support, and in one case were left feeling blamed. When the children were excluded from school, this increased the burden on the parents with little consideration as to whether the parents were better placed to manage the subjects challenging behaviours. The parental support provided by mental health services is through post diagnostic workshops. In addition, parents are able to contact the child's allocated worker or the duty worker. However, for parents with learning needs it is clear that a more diverse package of support is required.

1.4.9 Child R was exposed to Domestic Abuse from her brother to her mother in 2015 the impact of this was not sufficiently assessed or understood.

1.4.10 The reviewer learned there is now parenting support for children with additional needs – there are local provisions available. Parents who missed the opportunity can now access the service via Point.

1.4.11 There is evidence to suggest that both parents were hiding the frequency of the violence they were experiencing from the child, but eventually they got to breaking point and this is when the information was disclosed. There was a referral to Multi Agency Risk Assessment Conference (MARAC) for the child to parent violence and to encourage the parents to engage with CAMHS; the referral was not accepted due to the child's age. A review of the school placement took place. A residential placement was considered, and a section 47 investigation commenced, as it was assessed that the child was beyond parental control.

1.4.12 There was a referral to Youth Justice Service (YJS). YJS intervention was not assessed as being suitable and a decision was made to divert the offence to the Mentally Vulnerable Offenders Panel (MVOP). The MVOP agreed to divert rather than pursue a criminal pathway. Care, Education and Treatment Review (CETR) was led by Health, and the search for a therapeutic placement began. It appears that professionals were trying to establish where this case should be managed Oldham have an escalation policy partners can use when cases are being passed around systems and don't appear to 'fit'.

1.4.13 There was a suggestion that one of the parents in this case might have additional learning needs. School staff felt that an interpreter might have been helpful to enhance mother's understanding of Autism and ADHD, but this did not occur. Others have made a clear determination that there were no language barriers or learning needs. The GP had flagged this parent's records to indicated additional learning needs however no formal assessment was ever requested or conducted. This is currently being reviewed and a referral for assessment will be progressed if deemed appropriate.

[9] https://www.theguardian.com/society/2018/dec/09/what-happens-when-your-child-becomes-violent-with-you

**Learning point:** It can be concluded by the examples given that during the review period there was not a full and consistent response to children and their parents when additional issues arise. Whilst there is work being done to look at the response to cultural differences, there is currently a gap in service provision within Oldham. There is no service commissioned to work with and support families who are experiencing child to parent violence.

**Recommendation:** Oldham LSCP and its partners to consider whether current practice takes account of cultural and social circumstances. Oldham LSCP and its partners to consider how they wish to manage child to parent violence and work with commissioners to commission an effective service.

## 1.5 Use of current policies, procedures and systems in managing complex and challenging cases.

1.5.1 Within this section the reviewer will consider how Oldham make use of their framework of policies, procedures and systems to coordinate and manage complex and challenging cases. Consideration will be given to who might get missed, funding pathways, available resources, budgeting pressures within agencies and whether this led to earlier interventions not being actioned.

1.5.2 Oldham's current framework of policies, procedures and systems is not assisting practitioners to coordinate and manage challenging and complex cases. There is a lack of strategic direction and no Complex Case Forum. Agreement has yet to be reached regarding which services should be engaged if such a forum was to be established. The partnership has discovered that they are not clear what is meant by the term complex and are yet to agree the criteria they would use to determine if a case is complex. Additional concerns have been expressed that concentration is on the service rather than the child, and parents indicated they did not understand the terminology professionals were using as it had not been explained; this is especially problematic when working with families where there are language barriers.

1.5.3 Practitioners working with complex cases are working within their own agency's systems, policies and procedures. What is absent is a comprehensive overarching Safeguarding Board multi-agency procedure and process to assist partners. As a result, it is understandable that there was poor co-ordination of the multi-agency response in these cases. By nature of the service the co-ordination fell to the children with disabilities service however, all services had a responsibility to contribute or challenge when progress was not being made; there was a lack of challenge between agencies.

1.5.4 There is significant evidence that individual practitioners and individual agencies were trying a range of interventions to try and keep the subjects safe. However, given the complexities involved in these cases these interventions were extremely unlikely to have been effective. The lack of multi-agency approach, drawing on each services specialist knowledge, meant assessments that were conducted lacked a depth of understanding of the children and their families lived experience. This, in turn lead to a rather simplistic approach to keeping the subjects' safe, that did not take sufficient account of the complexities of the cases and placed much of the responsibility for keeping the subjects safe, on their parents without providing them with a level of support they might need to do so. A situation which left one subject distressed led to her going missing and being abused.

1.5.5 Child Q's parents originally contacted CSC as the route to gaining short break provision. A decision was made that a single assessment was required. It has not been possible to analyse fully the decision not to complete a single assessment and only

consider short break provision or understand the delay in developing a Child in Need plan. However, it is clear that both situations have come at a considerable cost both to the individuals and the Local Authority. A lack of multi-agency co-ordination and intervention at an early point is often costly and whilst there is a necessity to use resources wisely, delay can prove costly. It can be seen in both these cases that the lack of early preventative work has contributed to the requirement for highly specialised and hugely costly service provision toward the end of the review period. In addition, parents did not receive what they had requested.

1.5.6 Children with disabilities are often subject to a range of assessments and this can lead to a need for an intervention. The Education and Health Care (EHC) plan is key as it outlines the type of support or intervention that a child will receive to ensure their needs are met. Ofsted in their inspection[10] found that the quality of EHC plans was wholly unacceptable. Outcomes were not written in a manner that was meaningful to either the children and young people, or the professionals using the plans. They found that a number of young people had additional plans that sat outside the EHC plan which was leading to duplication and disjointed provision. The interface between the EHC plan and any plan required via safeguarding processes is unclear.

1.5.7 Services are under resourced. Post Adoption help has limited provisions and is further impacted as there is a culture that parents who are more vocal will receive what resource there is. At the practitioner's event there was discussion regarding whether this was a fair service as parents with a lack of knowledge of their entitlements, or complaints procedures are being disadvantaged. Within Oldham knowledge of what services are available in the area and accessing those services information is mainly online, this is a major barrier to parents who are not computer literate or have no computer/internet access. GP, Social Services, Community Centres, Coffee Mornings, and Parents Evenings can signpost families to services, but this requires a proactive response by parents and carers. Parents reported to Ofsted a lack of activities and clubs for children with more complex needs; this lack of appropriate support was contributing to family breakdowns.

1.5.8 Decisions regarding funding are often made on a single agency basis however it is clear that where there are both social care and health aspects to the support required, agencies have worked together to provide jointly funded packages of support. What is less clear is whether multi-agency panels have access to an agreed joint funding stream that can be accessed at points where a child or young person and their carer requires high level support through complex interventions.

1.5.9 An access to resource request was made for one of the subjects. The Social Worker suggested a package of care for the young person that was considered by the panel. That package of care was not agreed. The Social Worker makes reference to disguised compliance by the parents who have indicated they wanted their daughter to receive specialist provision. The reviewer is of the opinion that the parents were represented negatively and suggests their request was reasonable. It is clear from the minutes of that meeting that there was a struggle to identify a suitable service with capacity to care for the young person within Oldham, and a lack of suitably qualified staff who had received additional positive behavioural training to work with the young person. The panel agreed Early Help intensive support to assist the parents to get the young person to school and administer her medication, and some short break provision that was not available for two months. Whilst the panel were provided with the young

[10] Ofsted (2017) Joint local area SEND inspection in Oldham

person's diagnoses but there is no information about how they impact on the young person within the meeting. The reviewer considers that the requested package of care and the agreed package of care did not give full consideration to the risks and was not supported by an understanding of the young persons' behaviours in the context of their diagnoses.

1.5.10 Workload and budgetary pressures are two factors that threaten professional practice and imperil children's safety and welfare.

**Learning point:** The lack of a multi-agency complex case forum with associated policies and procedures is leading to silo working of complex cases. This is impeding agencies from taking a co-ordinated, proactive approach to complex case management and reducing the effectiveness of agencies work with the child and family.

**Recommendation:** Oldham LSCP and its partners to develop their approach to complex cases through the development of a complex case forum supported by clear policy and procedures.

## 1.6 How do we plan transition of complex case within children's services and between children's and adult services?

1.6.1 Planning for and transition to adult services should commence at 14. There's evidence that this is underdeveloped in Oldham and requires significant development. For one of the young people in this review there was no plan for transition and for the other young person, other than a referral to the transitions worker there were also no plans in place.

1.6.2 Transition of children with complex needs is a complex process in its own right and should encompass thinking regarding the young person's level of understanding, abilities, health and social situation. Whilst it is the transitions worker who will complete a Care Act assessment prior to the subjects 18th birthday's, there is little to demonstrate that children's services and partner agencies were considering what other interventions might be required. There was no thought given to understanding the subject's capacity to make decisions and take risks, and whether those involved in their care were making decisions that were in their best interests. Involvement of Adult Services at an early juncture will assist the smooth transition between services for both the subject and their parents.

1.6.3 The transition period should be used to prepare both the child and parents for their transition to adulthood and the changes that this will bring in terms of service provision, information sharing and the inevitable increase in taking action based on the child's wishes and decrease in parental control. For the parents of children with learning disabilities and complex behavioural issues, these changes can evoke increased worry, stress and anxiety, and for the children, increased risks. Full and effective use of the period prior to transition has the potential to reduce these worries and risks. There needs to be a multi-agency co-ordinated approach to transitions in complex cases to mitigate the risks.

**Learning point:** Transition is underdeveloped within Oldham. Autistic children at the stage of transition to adulthood, are likely to struggle with the Adult services approach, due to their individual circumstances. Transitions is now seen as a priority in Oldham. SEND are planning to include this in the Annual Review process and feel that this would have been appropriate in these two cases. A Multi-Agency Policy is being co-ordinated across the partnership.

**Recommendation:** Oldham LSCP to seek assurance that changes to the transitions policy and process are resulting in children and families being better prepared and supported to manage the change.

## 1.7 Was the voice of the child captured? How is this different for children with additional needs e.g. SEND, LD, autism, ADHD? Can we see this was acknowledged with changes in practice to reflect this? Is there evidence of consideration of children's right v parental rights as the subjects moved towards adulthood?

1.7.1 Across services there is limited evidence of the voice of the children held within records. Those services who do not have specialist professionals in communicating with children with learning difficulties did not question the children at all, indicating in their records that the children had autism as explanation. This suggested a lack of knowledge and skill around talking to children with additional needs.

1.7.2 The reviewer acknowledges how difficult it can be when communication is a barrier however, it is imperative that this is acknowledged and that if professionals are unable to communicate with a young person the expertise of partner agencies is sought.

1.7.3 It is clear that some services altered their ways of working in light of the subject's diagnoses. This is evident in the youth justice service initial home visit and missing from home return interview with Child Q. However, this stopped short of seeking Child Q's views on her offending behaviour and on being diverted via MVOP. Professionals were unable to engage both children with services on a number of occasions. This inability to engage the children prevented professionals gaining greater understanding of the children's thoughts, wishes and feelings; even professionals with experience in adapting communication styles, found it difficult at times. CAMHS professionals attempted to engage one of the subjects in different settings, providing psychologically informed work to the school, as she engaged with school staff better than healthcare professionals. Whilst CSC did gain the subject's views at various points throughout their involvement, their voice was not evident in planning and intervention. Child Q's parents voiced their concerns that Child Q's was not listened to.

1.7.4 CSC practitioners reported that there have been recent changes to try to address the lack of the child's voice/lived experience, the Disabilities Team practitioners were keen on using this process, but the reviewer learned not all CSC Teams were adopting it. SEND have also changed their systems, so they are now able to access information not previously available. Managers can challenge Social Workers to ensure that information is available. SEND practitioners also stated that they had access to other education systems, but Health does not. Schools have lengthy case studies on both cases (including a daily diary) due to their complex nature, these are now available through the Child Protection Online Monitoring and Safeguarding system CPOMS system. In these two cases, everything was there, which was said to have helped with planning.

1.7.5 There is little evidence of consideration of child's rights v parents' rights as the children moved into adulthood (see section 3.6). Early Help stated that they work more around the child's wishes, managing the expectations of the parents, on whether the child will return to the family home at the end of the CSC provisions, as they are now under Adult Social Care. It is not unusual for parents to have difficulty in letting go of their child as they move into adulthood; this is particular so for parents of children with additional needs. School indicated they felt that there should be increased listening to

the child's preferences but recognised the need to take into account that the child may not always be presenting as their true selves. There needed to be increased consideration of the child's capacity to make decisions. Currently EHC plans are completed for the year, then reviewed to see if they can continue past landmark birthdays (e.g. 16,18,25). Parents views are included in EHC plans but the voice of both parents and children needs to be more apparent within action planning.

**Learning point:** Practitioners who are not specialists working with children with conditions that affect their communication currently lack the skills needed to communicate and capture the voice of the child. The current way of developing children's plans is not demonstrating that sufficient account is being taken of the child's wishes and feelings.

**Recommendation:** Oldham LSCP and its partners to consider ways of upskilling their frontline workers to engage with and take account of the views of children and young people who are seen as "Hard to engage".

## 1.8 Do current policies, procedures, systems and practice support children with additional learning needs to receive education in the most appropriate way? Consider children excluded from education and home schooling.

1.8.1 Both children in the review went missing on a number of occasions. Children who go missing are at risk of violence, victimisation, sexual exploitation and involvement in crime. A child who goes missing just once faces the same immediate risks as those who go missing on a regular basis.

1.8.2 Both children were also excluded due to their challenging behaviours on a number of occasions. The school felt that they did not have much choice than to exclude the children, due to the difficulties with their needs and exhibited behaviours. As a result of exclusion, but as a bid to maintain them in education, they both had periods of being schooled at home both with and without support from the school.

1.8.3 Children missing from education[11] sets out key principles to enable local authorities in England to implement their legal duty under section 436A of the Education Act 1996 to make arrangements to identify, as far as it is possible to do so, children missing education (CME).

1.8.4 Statutory guidance places a duty on schools to avoid permanently excluding pupils with an EHC plan (DfE, 2015[12]). Survey data from parent-advocacy organisations highlight the potential scale of the problem for autistic pupils specifically. Of the 980 parents surveyed by the UK charity, the National Autistic Society in 2016[13], nearly one in five reported that their child had received at least one fixed-term school exclusion, and one in 20 had been permanently excluded.

1.8.5 In the practitioner's event school staff identified that there are now separate provisions for children with Autistic Spectrum Condition (ASC), Education Health and Care (EHC) and Social, Emotional and Mental Health (SEMH) needs, but there seems to be a gap between these. The School does not have the holistic therapeutic provision on site, and they felt that this is what the children needed, as they were was

[11] Department for Education (2016) Children missing from education – Statutory guidance for local authorities: September 2016.

[12] Department for Education. (2015). *Special educational needs in England: January 2015*. Retrieved from www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015.

[13] Moore, C. (2016) School report 2016, London: The National Autistic Society.

not ready for an academic focussed provision, and it was felt that there were probably a more cases like this in Oldham. SEND noted that there are about 2,500 with ASC plans in Oldham, but there are only two new Independent Special Schools which opened recently to bring children back into the borough where they reside, to comply with the duty to educate children in their home borough. These new independent schools were not available at the time of these cases.

1.8.6 School made adjustments providing Child R with reduced timetables, but there was a lack of structure in attendances. CSC felt schoolwork was not being done at home, it was also felt that Child R had been let down by many schools and, this is when some of the issues started. Home tutors were brought in, SEND felt that whilst the minimum of education, e.g.; English and Maths was offered, but other activities and interactions with other children were missing.

1.8.7 CSC advised that they received many calls from both the Mother and School that the child either did not want to go to school or leave once she was there, but during home tutoring period, these issues were not reported giving the impression that the issues had been resolved.

1.8.8 SEND reported they had observed that as Child R got older, there was more interaction with platforms such as social media, Instagram etc, and that she was interacting less with her Mother.

1.8.9 CAMHS Psychologist feels that there is a gap in provisions in Oldham, and there is an expectation for parents to deal with complex children being tutored at home, and that in this case there had been a lack of boundaries set in the home environment. School Nurse feels that the Mother struggled getting the child 'to do things', it was easier to let the child do what she wanted, as she could be very physically difficult. There was also a noted weight gain during the home tutoring period, as the Mother would feed her whenever and whatever she wanted it to keep her 'happy'.

1.8.10 There does not seem to have been sufficient challenge or consideration to the impact on the subjects and their family's as a result of exclusion from school by any of the agencies. Given the complexities of the subjects needs it could be reasonable anticipated that during adolescence their vulnerability to CSE would increase due to social isolation and developing self.

1.8.11 The children subject to this review are not unusual. A significant body of evidence suggests that some autistic children are not having their right to an education fulfilled and are missing a significant and concerning amount of school. Research was conducted in Scotland with parents of autistic children who had missed school within the last two years. A total of 1,417 responses were received,

- 185 parents (13%) said their children had been formally excluded from school in the last two years.
- 478 parents (34%) told us their child had been unlawfully excluded in the previous two years.
- 394 parents (28%) told us their child had been placed on a part-time timetable in the last two years.
- 1,004 parents (71%) said that their child had missed school for reasons other than common childhood illness in the last two years.

Nearly three quarters (72%) felt that staff having a better understanding of how their child's autism affects them, including their communication needs, would have made a difference to their child. The Scottish Government's statistics on school exclusions and

attendance show that the exclusion rate for pupils with additional support needs is almost five times higher than for those without additional support needs. the impact their child missing school has had on their child's wellbeing and that of their families. [14]

1.8.12 Research into autistic children's experience of school concluded the culmination and escalation of challenges students experienced in the students' previous placements could suggest that the educational journey to exclusion from school is an inevitable consequence for at least some autistic children, including those with particularly complex behaviour, as sampled here[15].

1.8.13 At the practitioner's event school advised that the Local Authority does offer some support, there are many agencies involved, many meetings taking place, but it felt like there was never a robust enough plan, and there was a lot of chasing people up on actions from these meetings. Plans would work for a while (e.g. increased hours at school), but then the child would start resisting. SEND felt one of the children was exhausting everyone involved, as she kept changing her tactics, and that this was preventing positive outcomes. The situation/case was effectively 'stuck'. Understanding the triggers, may have been an issue, but was the focus in the right place, school felt that it was not, that a more therapeutic approach was needed, although she was more than capable of achieving in the academic areas.

**Learning point:** Management of children exhibiting challenging behaviours in a school setting is complex. School were not well supported and were expected by partners to manage. This stance caused issues between services and prevented an earlier multi-agency co-ordinated approach to manage the behavioural issues and risks. This issue is no longer viewed as an educational issue but as a multi-agency issue. There are now weekly multi-agency meetings and an increased use of escalation policy's which should result in a multi-agency approach prior to exclusion. An outreach provision is being developed to help schools to manage the educational needs of these children more effectively.

**Recommendation:** Oldham LSCP and its partners to seek assurance that the new ways of working are reducing school exclusions for children with learning disabilities/Autism.

## 1.9 Is the current response to children with additional learning needs who go missing taking sufficient account of their extra vulnerability?

1.9.1 One of these young people was not recognised by some as having learning difficulties. It was deemed her learning needs were being affected by her behaviour rather than aspects of her condition were impacting on her behaviours and affecting her learning. This suggests a lack of knowledge amongst professionals regarding the full scope of the term learning difficulties and that those young people who have high functioning autism might not be.

[14] Children in Scotland, the National Autistic Society Scotland and Scottish Autism (2018)
Not included, not engaged, not involved: A report on the experience of autistic children missing from school https://www.notengaged.com

[15] Brede, J., Remington, A., Kenny, L., Warren, K., & Pellicano, E. (2017). Excluded from school: Autistic students' experiences of school exclusion and subsequent re-integration into school. *Autism & Developmental Language Impairments*. https://doi.org/10.1177/2396941517737511

1.9.2 There were multiple occasions when the subjects went missing and whilst these episodes evoked an immediate response from services, services were not working to clear plans on how to manage those occasions. Had trigger plans been in place they would have prompted partners to consider factors that might lead to a missing episode and provided clarity on each agency's role at the point the subjects went missing. The lack of a trigger plan and a multi-agency plan to manage these situations in a safe, supportive and consistent manner likely added to the confusion, fear and distress one of the subjects displayed. The CSC author considered there were a number of missing episodes where concerns reached the threshold for a section 47 investigation and strategy meeting, but this was not triggered.

1.9.3 The subject's distress at these times could have been reduced if an advocate had been appointed, someone who knew them well and to whom they could relate. The missing from home procedures do not acknowledge the additional complexity children with learning disabilities may experience.

**Learning point:** The response to children with additional learning needs who went missing was not taking sufficient account of their extra vulnerabilities. The lack of use of trigger plans and advocates both reduced the opportunity to take a proactive response and left the child distressed. The missing from home policy is currently being updated.

**Recommendation:** Oldham LSCP and its partners to ensure the updated missing from home policy is clear regarding the need for trigger plans and advocacy.

**Recommendation:** Oldham LSCP to seek assurance that trigger plans and advocacy services are being utilised on all occasion when children with additional learning needs go missing.

## 1.10 How did we manage, recognise and respond to the potential of a forced marriage?

1.10.1 Early indicators of the potential for forced marriage were missed by all agencies. One service had knowledge that an older sister of the subject had fled the country to avoid a marriage. This information had not been referred or shared across the agencies involved with the family. Practitioners did not respond in line with Oldham's policies and procedures. It took the child to vocalise her concerns that she was scared to go to Pakistan with her father, with whom she had no contact for five years, to prompt the practitioner to refer the case to CSC.

1.10.2 The response by CSC was not robust; there was a readiness to accept the family report that they had no plans to go to Pakistan. The child's report of being scared to go was not sufficiently explored. There was a lack of recognition of the potential for forced marriage, with a spurious conclusion that it was parental choice. Once a stance had been taken that it was parental choice, no further action was considered as necessary to safeguard and promote the welfare of the child. Had the danger the child was in been considered in line with procedures, a more proactive approach should have been taken and contact made with International Social Services (ISS).

1.10.3 The response on this occasion was not robust. If this is representative of how potential cases of forced marriage are being managed this presents significant risk. Oldham professionals are supported by Project Choice which provides advice and support to professionals and those experiencing honour-based violence and abuse, including forced marriage.

**Learning point:** Professionals across all the involved agencies were not sufficiently sighted on the potential for forced marriage suggesting a gap in knowledge and understanding.

**Recommendation:** Oldham LSCP and its partners to explore whether the current approach to upskilling and supporting frontline practitioners to identify and manage cases where forced marriage is a potential issue is sufficiently robust.

## 1.11 What support was/is there for Parents following diagnosis for Disability issues, e.g.; ADHD, ASD etc.

1.11.1 Within school support is offered to parents to further understand their child's diagnoses. The parents of both the subjects were offered classes to help develop their understanding, however it is not clear whether they understood or took up this offer.

1.11.2 There was no information within the CSC records to indicate whether support had been offered or received by the parents during the diagnostic and post diagnostic period. At the point of diagnosis, there should always be consideration of what that diagnosis means for the child, their parents and what services are in place to support them both. One explanation for one of the subjects challenging behaviours had been around attachment issues between the child and mother. There is no evidence that there was consideration that in light of her diagnosis of autism, this might be an additional factor impacting the parent child relationship, or indeed the only remaining factor given the therapeutic interventions that had occurred when the child was younger.

1.11.3 CAMHS also offer support post diagnosis and families are now directed to on-line support.

1.11.4 Practitioners were not confident that the services that are available are being accessed equitably.

**Learning point:** There is a lack of robust co-ordinated support for parents following their child receiving a diagnosis of a disability issue. Access to support is largely parent led and whilst this might be an appropriate approach for most families, some families might be less confident to request support. Parents should be actively encouraged to access support and practitioners should direct families to support when they identified increased need, including exclusions from school and home schooling, and initiate a Parent/Carer assessment. The policy on Parent/Carer Assessments is currently being updated.

**Recommendation:** Oldham LSCP to seek assurance from partner agencies that they have collectively considered and agreed the current standard offer of support, to all parents with children with Learning Disabilities, with additional tailored support being made available as required.

**Recommendation:** Oldham LSCP to seek assurance that Parent/Carer Assessments are being completed with all parents of children with additional learning needs who are excluded from school and being home schooled.

## 1.12 Giving consideration to the transforming care agenda, have we been able to commission specialist services effectively for those people with a learning disability and/or autism who display behaviour that challenges?

1.12.1 The transforming care programme aims to improve the lives of children, young people and adults with learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.[16] There are three key aims; to improve quality of care, improve quality of life and enhance community capacity thereby reducing inappropriate hospital admissions and lengths of stay. There are limited resources available within Oldham and specialist services appear to be commissioned on a case by case basis. This might be viewed as extremely responsive to an individual's needs, and in line with the ethos of the transforming care programme. However, the reviewer is not confident that those making the decision regarding commissioning specialist services, have sufficient evidence to assess what is required, because the child's needs have not been fully assessed and those assessments analysed. The lack of complex case management means that there is a gap between the generic community-based offer, and the highly specialised placement offer.

1.12.2 Care Education and Treatment Reviews (CETR) are designed for anyone with a learning disability, autism or both who is at risk of admission to or is in a specialist learning disability or mental health hospital. Poor and lack of assessments with robust analyses in general, combined with a lack of use of recognised processes for example CETR, has made it difficult for the reviewer to analyse whether the systems in place, have led to the commissioning of the right services in these cases. Whilst it is clear that the out of area provision commissioned for one of the subjects has brought stability and a reduction in risk taking behaviours, the reviewer cannot be confident that this was the best option for the child longer term.

1.12.3 The other child remains in the care of her parents, and whilst this is positive, the reviewer has yet to see evidence that she is receiving appropriate support from specialist services to keep her safe and meet her needs.

**Learning point:** Lack of use of assessment tools to assess children with learning disability/ autism who are displaying challenging behaviour, has led to a lack of understanding of which specialist services were required at an earlier stage, that might have assisted and kept the children safe.

**Recommendation:** Oldham LSCP to seek assurance that all children with LD/ Autism are receiving appropriate assessment and have access to specialist services when they are exhibiting challenging behaviours.

## 1.13 Does the process around child protection conferences ensure parents are fully aware of the nature of the meetings and concerns of professionals before they attend?

1.13.1 An Initial Child Protection Conference (ICPC) was convened for one of the subjects in July 2018. The accepted process in Oldham is that parents will receive an invite to the meeting and professionals will share their reports with parents prior to the meeting. The Independent Reviewing Officer will then discuss the conference with the parents immediately prior to the meeting. In this case the parents were not invited in a way that made it clear to them the nature of the meeting. Parents informed the reviewer had they known in advance they would both have been present and the subject child would not have been brought. When the Independent Reviewing Officer (IRO) discussed the conference with the subjects Mother, she indicated she was not

[16] https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf

agreeing to the meeting as she had read up on it, and she did not believe her child was at risk of harm. The current process of waiting until just prior to the meeting to discuss the conference with parents is not allowing time for parents to assimilate the information and for further discussions and challenge of the content of reports to occur.

1.13.2 The reviewer learned that reports are not always shared with parents prior to the meeting or maybe shared as the family arrive. Parents only recall receiving one report prior to the meeting. Some of the reports contained language that would seem inflammatory to most people and, if hearing this for the first time, could have been deeply upsetting. They contained language that strongly suggested they (the parents) were to blame for their child's behaviours. Brandon et. al (2020)[17] found that the language we use to talk about children's circumstances can both support and hinder effective safeguarding. It is clear that it was a hindrance in this case. The CSC record of the reasons for the conference indicate that this was due to attachment issues, the child's vulnerabilities, and her violent behaviours within the home and at school. The record suggests these behaviours were thought to be due to a lack of boundaries and routines within the family home. Mother was locking the child in the house to keep her and others safe. It was noted mother clearly loved the child and father was at the end of his tether.

1.13.3 Whilst parents were informed of a meeting, their complaint was that they had not been made fully aware of the nature of the meeting and felt their parenting was being criticised and they were being blamed. Being blamed ultimately led to a lack of trust. The decision of the professionals was to place the child on a child protection plan under the category of emotional abuse. The parents made an official complaint much of which has been upheld. The process was flawed, not open and transparent, and as such it was determined that the meeting should not have taken place.

1.13.4 Following this meeting, as with previous meetings, there was a delay in minutes being received and the accuracy and quality of the minutes was a cause for concern. Parents report minutes were often received on the day of the next meeting leaving no time to read and digest them and that group membership changed so frequently that minutes could not be ratified.

1.13.5 There have been some changes to Police practice in relation to child protection conferences. These are now attended by a member of the newly formed Case Management Team. These teams sit within each district providing a much more 'locally owned' service which, it is believed, has brought about improvements to the decision making process, increased ownership of risk, and increased opportunities to challenge if it is felt the most appropriate intervention is not being provided at the earliest opportunity.

**Learning point:** The way child protection conferences were being convened and managed was not preparing families or allowing families to express their opinions regarding the conference. By not ensuring families are receiving reports prior to the day of conference, families are not being given sufficient opportunity to understand professionals' concerns and challenge, prior to their attendance at conference.

**Recommendation:** Oldham LSCP to seek assurance that partner agencies are complying with procedures in relation to child protection conferences.

[17] http://www.assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment

## 2. Conclusion

2.1 The subjects of this review have experienced significant harm at the hands of adults who have exploited their vulnerabilities. Services best placed to protect these children did not keep them safe.

2.2 Systems and processes designed to prevent and protect children in Oldham were not sufficiently robust for those children with additional needs. The lack of a robust multi-agency response to identified concerns, including an impartial Child and Family Assessment, multi-agency planning, and outcome focussed intervention, meant opportunities to take actions that could have prevented the children experiencing harm, were missed.

2.3 The complex nature of these cases was not sufficiently recognised, and whilst there are pockets of good multi-agency information sharing, there was a lack of analysis as to what this information meant. Aspects of the children's behaviours as a result of their diagnoses, were too readily attributed to shortfalls in parenting. This led to professionals focussing on what the parents needed to do to keep the children safe rather than what they, the professionals, needed to do to keep the children safe.

2.4 A lack of knowledge amongst partner agencies regarding the potential reasons for the children's risk taking and violent behaviours, and a lack of direct work with the children, lead to limited understanding of their, and their parents lived experiences.

2.5 A belief that because the school was commissioned to work with children with ASD meant they should be able to manage the children's behaviours, left the school trying to manage the distressed behaviours of the children in isolation. Partner agencies did not take account that the children may have additional therapeutic needs. Skilled school staff were clear that they were increasingly struggling to safely manage the children's behaviours. A multi-agency approach through either a Children in Need or the EHC plan may have brought into focus whether the children were in receipt of the right support and services, and whether they were in the most appropriate school placement.

2.6 Decisions to exclude the children from school eased the situation in school but had the unintended consequence of increasing the vulnerabilities for the children, and the difficulties for the parents. School exclusion also lead to a decrease in the level of contact between the children and the professionals best placed to protect them, with limited additional services being offered.

2.7 The lack of a co-ordinated multi-agency response, with CSC at the helm, did not serve these children and families well. When there was an increase in the children's risky behaviours, this led to one of the children being place on a child protection plan. The focus of this plan was on the risk of emotional harm from the parents. From the parent's perspective, this must have been very difficult to accept, and it is unsurprising that they made a complaint. Sadly, they remain mistrustful of services and have indicated they would not ask for help in the future.

2.8 Oldham was not well resourced and access to the resources available was not always based on need. It had been a period of churn and Oldham has been on an improvement journey since 2017. Whilst there has been an increase in stability of management and there is fresh focus, the lack of strategic direction, policies and procedures to manage complex cases through partnership working remains a concern.

## Glossary of Terms and Abbreviations

| | |
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| A&E | Accident and Emergency |
| ADHD | Attention Deficit Hyperactivity Disorder |
| ASC | Adult Social Care |
| ASD | Autistic Spectrum Disorder |
| CAMHS | Child and Adolescent Mental Health Services |
| CETR | Care, Education and Treatment Reviews |
| CIN | Child in Need |
| CME | Children Missing Education |
| CP | Child Protection |
| CPOMS | Child Protection Online Monitoring and Safeguarding system |
| CSA | Child Sexual Abuse |
| CSC | Children's Social Care |
| CSE | Child Sexual Exploitation |
| CSPR | Child Safeguarding Practice Review |
| CWD | Children With Disabilities |
| ED | Emergency Department |
| EHC | Education and Health Care |
| FGM | Female Genital Mutilation |
| GP | General Practitioner |
| ICPC | Initial Child Protection Conference |
| IRO | Independent Reviewing Officer |
| KOGS | Keeping Our Girls Safe |
| LSCB | Local Safeguarding Children Board |
| LSCP | Local Safeguarding Children Partnership |
| LD | Learning Disability |
| MACR | Multi-Agency Child Review |
| MARAC | Multi Agency Risk Assessment Conference |
| MASH | Multi-Agency Safeguarding Hub |
| MH | Mental Health |
| MVOP | Mentally Vulnerable Offenders Panel |
| PCSO | Police Community Support Officer |
| SEND | Special Educational Needs and Disability |
| SW | Social Worker |