Oldham Safeguarding Children Partnership

Local Child Safeguarding Practice Review

Thematic Review of Harmful Sexual Behaviour

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1. Foreword

The Oldham Safeguarding Partnership is committed to continuous learning and improvement, we thank all those that participated and supported the review. The partnership welcomes the finding of this review to guide our practice to improve the lives of children in our borough.

2. Introduction

2.1. In December 2020, the Oldham Safeguarding Children Partnership (OSCP) scrutinised two separate cases where young people had suffered significant harm, and which had involved Harmful Sexual Behaviour (HSB). They recognised the potential to improve the way agencies worked together to safeguard young people and commissioned this Thematic Learning Review. An independent reviewer was appointed to work with the safeguarding partners in a thematic review of safeguarding practice in relation to Harmful Sexual Behaviour.

2.2. The Safeguarding partners considered both cases against Working Together to Safeguard Children[i] and the panel decision was that neither case individually met the criteria for a Child Safeguarding Practice Review, but that meaningful learning would come from a Local Thematic Learning Review. Thus, the two practice examples have been considered to guide a wider review, focusing on strategic development rather than individual case learning.

3. Aim and Terms of Reference (ToR)

3.1. **Aim of the thematic learning review**

3.1.1. It seeks to consider a more coherent and evidence-informed approach for work with children and young people displaying signs of HSB, and to better understand how to improve outcomes for them.

3.1.2. The review will explore:

- Identification of harmful sexual behaviour
- Evidence informed multi-agency approaches
- Recognition of the other vulnerabilities and complexities including wider family functioning, other safeguarding concerns including domestic abuse.
- Learning disability, mental health, and communication
- Cultural competence
- Basic statutory safeguarding processes

3.2. **Specific Terms of Reference:**

- If basic safeguarding processed had been followed, would this have prevented further sexual harm?
- How did agencies recognise and respond to the growing awareness of HSB, and;
  - What multi-agency approaches do the partnership utilise to plan and share relevant information when there is a concern about HSB?
  - How well are additional vulnerability factors recognised and addressed in assessments, interventions and plans.
- What do family members say about the effectiveness of agency involvement? Which services made a positive difference and what could have been better?
- Did the agencies hear, listen to, and respond to the voice of the young person?
- Were the assessments, interventions and plans culturally informed?
- Are any changes to the local safeguarding arrangements required because of the learning from this thematic review?

4. Methodology

4.1. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the themes, analysis and findings (what went well and areas for development), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations.

4.2. An independent reviewer was appointed to work alongside a panel of local professionals who met regularly to undertake the review. Five panel meetings were scheduled through the time frame of the review for further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for further consideration by the Safeguarding Partnership.

4.3. A practitioner event was held consisting of frontline practitioners' representative of the key statutory agencies and relevant agencies. This facilitated a focus on the terms of reference and a baseline of practice in Oldham, a poll was conducted at the start if the event to consider initial views of HSB practice (Appendix 1).

4.4. Interviews were held with frontline practitioners from Social Care and Greater Manchester Police to gain insight into frontline practice.

4.5. Chronologies and single organisation reviews were provided by each agency, analysing practice events, and considering how changes to practice may deliver future improvement.

4.6. It was the ambition and plan for the independent reviewer to meet with family members to ensure that their views were fully considered, particularly how processes and procedures impacted upon them- this has not been possible to facilitate and will be expanded on later in this report.

4.7. This report is written with the intention of publication and as such does not contain information which may identify the young people involved. This is extremely relevant in both cases in view of parallel processes and active/ ongoing case management.

4.8. The detailed analysis of cases and the evidence underpinning this report are held in additional documents retained by the Safeguarding Partnership.

4.9. A methodology was agreed that would recognise good practice and strengths that can be built on, as well as areas that require improvements. The process was agreed to be proportionate, collaborative, and analytical, actively engage all agencies/organisations involved and family members.

5. Brief synopsis of the cases:

5.1. **Case 1**

5.1.1. Case 1 is a now 17-year-old male with 2 female siblings (now 15 and 10). He is British born to Bangladeshi parents. The siblings are under interim care orders within foster placements and subject is under a full care order living in a residential setting. All 3 children had previously lived with their Grandmother for 10 years. Case 1 has an Education, Health and Care Plan (EHCP) and had been assessed for learning disabilities on several occasions.

5.1.2. There is a complex family history with exposure to different forms of abuse, the full extent of this is not fully known with information still emerging. An Uncle, described as head of the family often controlled the decision making within the family, allegedly perpetrating forms of abuse- physical and emotional. There are also wider family issues including sexual exploitation of the Mother,

parental learning difficulties and mental health issues, widespread familial Domestic Violence and Abuse (DVA) and evidence of collusion to pressure children to withdraw allegations made.

5.1.3. The agency chronologies identify that Case 1 was demonstrating behaviour that presented a sexual risk to others for 10 years at least, this includes sexually harmful activity on social media. The incidents escalated in frequency and severity from 2018 when there were a cluster of events including a serious sexual assault on a bus, and an incident involving harm to an animal. In 2019 there was an increasing number of events relating to allegations of assaults, and a serious sexual assault allegation. The chronologies show a repeated cycle of school concerns, Children's Social Care referrals, Learning Disability & CAMHS referrals and confusing and contradictory allegations made within the family. Case 1 was managed with Child in Need processes. Concerns and allegations continue to emerge.

5.2. **Case 2**

5.2.1. Case 2 is a now a 17-year-old male who communicates using British sign language. He was born in Pakistan to Pakistani parents. He has 5 siblings, two of whom are still children (aged 14 and 6). In 2018 he disclosed that he had been raped by his older brother and outlined other sexual assaults perpetrated by him too. Family members reported a contradictory view that it was case 2 who had assaulted his older brother. The subject subsequently disclosed that he had sexually assaulted his younger female sibling, there were increasing concerns about his behaviour being a risk within the community leading to threats of retribution, there were additional concerns that he had touched his Mother inappropriately. He was subject to Child Protection planning and there were increasing reports of HSB from 2018. Little is known about his early years and experiences as he resided in a different country.

6. Family Involvement

6.1. Family members had been in contact with Partnership Business Unit and received contact from the team to advise them of the process and to seek their contribution.

6.2. Consultation with the professionals and agencies working with Case 1 and Case 2 concluded that for several reasons it would not be appropriate for the subjects to participate in this review. However other family members were initially identified and contacted to gain insight into the effectiveness of agency involvement and to explore which services made a positive difference and what could have been better.

6.3. Whilst it was the ambition and the plan for this review to thoroughly explore a range of issues with family members, due to the ongoing real time management of these cases and parallel legal processes, unfortunately it has not been possible to facilitate this. As a result, there is a missing context to this review.

6.4. By way of mitigation there have been extensive discussions with the identified Social Workers for both young people, which went some way to providing insight into the perspectives of the subjects and family members and this will be explored later in this review.

6.5. **The Young People**

6.5.1. **An Overview:**

6.5.2. The experiences of the young people are essential in guiding the review and the analysis of practice. Each case was considered individually, allowing the review to identify common safeguarding themes experienced in their childhood and in their adolescent years. This short overview provides context to the report.

6.5.3. Each person experienced significant Adverse Childhood Experiences (ACE). Common themes from their home environments included domestic abuse in the home, parental mental and emotional health issues, communication difficulties. Additionally, a factor was the absence of a positive and supportive adult relationship in their life. This was despite partnership agency involvement to support them and their families.

6.5.4. There were communication difficulties in both cases. Both families had members who did not speak English, and this was identified as a barrier and challenge. One case involved British Sign language which also presented a challenge in terms of how information was received by professionals, families and then interpreted.

6.5.5. Both cases demonstrate a plethora of early problematic behaviour that was recognised by agencies and that escalated over time

7. Experience and Views- explored via the Social Workers, Educational Providers and Greater Manchester Police:

7.1.1. The allocated Social Workers for both cases were interviewed as part of this review, this was to facilitate an advanced insight into the views of the young people and their families in the absence of direct engagement with them as part of the review. In both cases they showed a great deal of insight and knowledge of the young people, the siblings and family functioning. They offered open and transparent insights and reflections about their individual cases as well as the partnership context. These interviews facilitated a different perspective in both cases.

7.1.2. Representatives from GMP and Educational providers were also interviewed to gauge perceptions of their role, this was to gain an insight into the extent of what was known about these young people.

7.1.3. **Key points:**

7.1.4. **Case 1:**

7.1.5. The Social Worker for case 1 provided an overview and reflections of the case. She highlights the functioning and complexity of this family which she felt determined the direction of case management for many years. It is important to note that there is still new and emerging information that has been disclosed and therefore to date, the extent of abuse within the family is not fully apparent.

7.1.6. The Social Worker provided insight into the subject and his level of cognitive functioning, which is very low, this was part of the conclusion of the AIMS assessment. She highlighted that he had accessed pornography compulsively and his learning disability together with puberty must have been an extremely confusing and difficult time for him. He had not received the right timely interventions to support him to understand his feelings and the impact of his behaviour on others. It is apparent now with insights from the subject and his siblings that he hadn't been provided with the right barriers, structures or understanding about truthfulness and he was extremely frightened of his Uncle.

7.1.7. She reflected that his lived experiences and views were not fully understood, but his outward behaviour over several years should have indicated that things were very wrong. She provided snapshot of family life for the subject, his siblings and the professionals trying to work with them. She felt that there was indication that significant harm was occurring in the house, but the other children in the household were unseen and unheard and the voice of the Mother was never

taken into account. This was largely due to a very dominant Uncle who assumed the position as head of the family.

7.1.8. This was explored and discussed in detail, the emerging picture is that of a person whose behaviour often determined the outcome of a conversation, process or assessment- professionals were extremely fearful of the Uncle due to his aggressive manner. The rest of the family were also very fearful of him, and in the view of the Social Worker "no one was allowed to be heard". In particular there were some specific gender issues that emerged in that the sister who alleged that she had been sexually assaulted by the subject was called a liar, blamed for her appearance and ultimately not believed and coerced to withdraw her allegation. At the same time there was another sister who was held up as a "good girl" because she was quiet, did as she was told and did not cause any trouble.

7.1.9. This was explored in terms of cultural competence, and it was established that Harmful Sexual Behaviour was a subject that was not fully explored with the family; however this can be said of many families and is not necessarily attributable to the cultural makeup of this family. Likewise, a dominant and controlling male who intimidates family members as well as professionals is not necessarily a cultural issue.

7.1.10. On reflection, the behaviour of the Uncle should have been recognised a significant barrier that prevented the siblings speaking out and succeeded in diverting lines of enquiry and stemming professional curiosity and thus an understanding of the level of abuse and harm that was occurring.

7.1.11. In particular, one of the siblings has been able to offer insight about the level of fear within the family, the issues she faced making an allegation of a sexual nature, the chaotic nature of the household and the lack of understanding about the level of risk to her and her siblings. Sadly, her opportunity to feel that she could safely speak up came later, after she had already suffered significant harm. This occurred at the point she felt she had a "trusted adult" who would believe her, this being the Social Worker. It is not known whether she had tried to tell someone at an earlier stage.

7.1.12. The conversation raised themes of multiple complexity, communications issues, lack of professional curiously, absence of the voice of the young person and fear of a dominant adult who intimidated professionals and family members. These together created a combination of factors that hindered basic robust multi-agency safeguarding practice progressing and additionally exploration of HSB at the earliest stage.

7.1.13. **Case 2:**

7.1.14. The Social Worker for case 2 provided insight into the challenges with communication and how this impacted on the effective understanding of complexity. There is a real absence of the voice of the subject for a significant time. She provided a synopsis of the subjects' background and the complexities of how the family communicated with each other using a combination of languages and variations of sign language. This makes it very difficult to evidence the voice of the young person and indicate that his lived experiences, frustrations, thoughts and feelings were not able to be taken into account. He was only able to communicate with one of his parents. We are not able to fully gauge his perception of what was happening for him and in his family. There is also an absence of information from his early years due to him living in another country, thus it is difficult to establish what his early experiences were like and how this may have impacted on his development.

7.1.15. Having the opportunity to reflect on the case allowed insight into the basic safeguarding practice and the response to increasing concerns about HSB and the challenges associated with communication- with him and family. In terms of HSB there were early indications of concerns,

he was accessing and watching pornography frequently and displaying stalking behaviour that persisted at least to the to date of this review.

7.1.16. The Social Worker has built a new chronology to pull his journey together more coherently and to understand the points that things could have been managed differently. She concludes that as far back as 2017 there was opportunity for agencies and professionals to come together and work with him and his family to put the right level of therapeutic intervention into place. She notes that there was an over focusing on assessments rather than an understanding of his own views and meaningful interventions. This led to a discussion about pathways and resources and the Social Worker is unsure of what resources would have been available and noted that there is an absence of shared pathways for HSB.

7.1.17. It cannot be established whether the information provided by the subject was understood fully or whether it was in turn shared effectively with the family in order for everyone to have a shared understanding of risk in order to formulate a safety plan.

7.1.18. **Police Perceptions:** A GMP representative who was largely familiar with Case 2 identified that at the point of time they were involved there had already been multiple previous incidents. This facilitated a discussion about the role of Police which identified that the point of time that Police become involved is often when something serious has already occurred. The representative reflected that HSB is an increasing issue that calls for a preventative approach with a view that there were opportunities to intervene earlier that has been missed in this instance. This allowed for some thought about the role of school-based officers and an opportunity to work with young people differently as well as joint working with partners to visit families.

7.1.19. It was identified that Police are often not quite clear on their role in contributing to a plan around a child, whatever part of the continuum this may be. It is often not clear who is taking the lead with incidents often being managed in isolation by one or another agency rather than as a full picture with a partnership approach.

7.1.20. In view of the points above it was concluded that not enough was known about Case 2 or his family in order to intervene early enough and plan effectively.

7.1.21. **Key thematic messages from both Social Workers:**

- A strong view emerged that key agencies should have worked together differently at a much earlier stage.
- There were multiple missed opportunities in both cases to work differently- a key being the coming together of agencies and professionals to collectively share information and consider the right pathway.
- Harmful sexual behaviour strategy meetings should have been held in both cases because this was lost in the wider complexity of the family functioning.
- The understanding of harm happening inside the families should have been explored.
- The communication barriers in both cases meant the professionals could not be confident that the families understood the extent of concerns OR that the range of professionals understood the poor functioning and harm that was occurring inside the families. This resulted in skewed views and a lost context.
- In both cases family members made decisions and set the direction of travel which was unhelpful and harmful for the subjects and their siblings. This was not part of an established safety plan agreed in collaboration with key agencies and professionals and was not effectively challenged.
- Both cases have a multiple complexity of issues that were never fully understood collectively- this was described by one Social Worker as needing a “complete jigsaw”.
- Disjointed communication and understanding.

- It is difficult to establish what information was understood and what was shared – consistency of approach was lacking
- There was a lack of robust risk assessment and safety planning.
- Both young people were known to be watching/ accessing pornography and this should have been a red flag in the context of emerging and increasing behaviours.
- An over focus of "tick box assessments" rather than a meaningful understanding of what they meant and how they informed a plan. The young people were "contained" to an extent rather than the addressing the root cause and behaviour.
- There is an absence of the views, experiences, voice of either young person.
- Professional curiosity was lacking and there was tunnel vision thinking, responding to individual incidents rather than robustly case planning.
- Neither Social Worker could fully describe the partnership strategy in Oldham or collective approaches to HSB and did not feel that the commissioned offer was clear enough when specialist assessments or intervention was needed.
- Both Social Workers were experienced, understood their cases well and were able to offer significant reflections and insights.

7.1.22. **Education perceptions**- In exploring some of these themes with educational providers there are similar and parallel concerns in terms of an understanding of who the "Lead professional" was, slow pace of change and lack of effectiveness and assurance from meetings and communications leaving the schools uncertain about what has been progressed.

8. Background and narrative

8.1. Background and research: What we know about Harmful Sexual Behaviour (HSB)

8.1.1. The recognised definition of HSB is as follows: "Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult.[ii]

8.1.2. HSB can be a challenging issue for professionals to manage. A child or young person who displays HSB can have a range of behaviours, which need a safeguarding response. Published case reviews show that professionals can find it difficult to respond to the safeguarding implications of HSB.

8.1.3. The learning from these published case reviews highlights that children who display HSB need support and understanding. HSB should be recognised as a potential indicator of abuse and professionals should work together to look for the reasons behind and child's behaviour and consider appropriate safeguarding responses.

8.1.4. There is increasing evidence of the scale, nature and complexity of HSB and albeit with a different focus to the terms of reference for this thematic review, the recent OFSTED review of sexual abuse in schools and colleges[iii] raises pertinent questions in terms of multi-agency safeguarding arrangements in the context of whether safeguarding guidance and processes between agencies should be strengthened.

8.1.5. Any child or young person who exhibits harmful sexual behaviour may need a safeguarding response or intervention. Professionals should respond with interventions that address the behaviour of the perpetrator, while also providing an appropriate level of support. Professionals involved should be aware that harmful sexual behaviour may be an indicator that the child has been abused.

8.1.6. According to Hackett (2014), professional awareness of children and young people with harmful sexual behaviours has grown, but significant variations and gaps in service delivery remain. This

was borne out by panel members, the Mentimeter poll and through group discussion at the practitioner event.

8.1.7. Children and young people's sexual behaviours exist on a wide continuum, from normal and developmentally expected, to highly abnormal and abusive. Assessing where any reported behaviour fits on this continuum can be a complex process. It is important to place any child's sexual behaviour within a developmental context and recognise the key differences between the motivations and meanings of such behaviours at varying stages of development.

8.1.8. It is therefore helpful to consider the baseline research into the continuum of sexual behaviour ranging from normal to violent. The model presented by Hackett (2010) is a recognised way to explain this continuum of behaviours, which can be displayed towards younger children, peers, older children or adults. It can occur online and offline or a mixture of both.

Definition: Sexual behaviours across a continuum

Normal	Inappropriate	Problematic	Abusive	Violent
- Developmentally expected - Socially acceptable - Consensual, mutual, reciprocal - Shared decision-making	- Single instances of inappropriate sexual behaviour - Socially acceptable behaviour within peer group - Context for behaviour may be inappropriate - Generally consensual and reciprocal	- Problematic and concerning behaviour - Developmentally unusual and socially unexpected - No overt elements of victimisation - Consent issues may be unclear - May lack reciprocity or equal power - May include levels of compulsivity	- Victimising intent or outcome - Includes misuse of power - Coercion and force to ensure victim compliance - Intrusive - Informed consent lacking or not able to be freely given by victim - May include elements of expressive violence	- Physically violent sexual abuse - Highly intrusive - Instrumental violence that is psychologically and/or sexually arousing to the perpetrator - Sadism

8.1.9. Research has been considered against the characteristics and themes of the cases that led to this review. "*A high proportion of young people across studies undertaken had extensive prior involvement with health and social care professionals prior to the emergence of their harmful sexual behaviours, as well as extensive histories of adversity, loss, discontinuity of care and insecure attachments. From the findings of these studies (and many others like them: for example, Richardson et al, 1995; Davis and Leitenberg, 1987; Awad et al, 1984; Becker et al, 1986; O'Callaghan and Print, 1994) it is reasonable to conclude that a significant proportion of young people with harmful sexual behaviours are from highly problematic family backgrounds and have experienced multiple disadvantages and adversities in their childhoods*"[iv]

8.1.10. Thus, the risks factors for the cases considered in this review were significant and required a coherent and consistent integrated approach.

9. Thematic Analysis against terms of reference:

9.1. ToR: If basic safeguarding processes had been followed, would this have prevented further sexual harm?

9.1.1. The characteristics and themes articulated in the first part of this report are identified as risk factors. We are aware from consideration of the agency reports that the young people were well known to agencies and various processes including Child in Need and Children protection that were already in place.

9.1.2. Panel members reflect that it is difficult to gauge and establish a rationale for some of the decision making which was often over reliant on Children's Social Care. Thus plans, interventions, assessments and engagements often did not seem to gain traction or evidence a positive outcome. There is some evidence of good individual practice and attempts to work with other agencies such as multiple conversations, telephone calls and escalations, however, in considering the agency chronologies it does not appear that there was coherent multi-agency case planning.

9.1.3. As a result of this, the increasing concerns about HSB (in instances and severity) were not clearly addressed and consequently drifted, in one case over a period of 10 years. Panel members and practitioners reflected on the reasons for this and felt that there were assumptions made that the emerging concerns would be addressed as part of other ongoing safeguarding processes. There was an over reliance on referrals and raising a concern than being assured that appropriate action was coordinated.

9.1.4. It is difficult to conclude without hindsight bias, however there is evidence to suggest that further harm may have been prevented if safeguarding processes had been implemented more robustly. This evidence includes the absence of HSB strategy meetings, the quality of partnership decision making, the period of time over which concerns were known and repeat strategy meetings with unclear outcomes.

9.1.5. The rational for decision making, process for risk assessment and formulation of safety planning is difficult to establish in either case, this is supported by the exploration of the cases with their Social Workers.

9.1.6. The question of frontline practitioners feeling confident to escalate is posed. In both these cases one or another professional felt concerned and frustrated but escalation or managerial supervision is not clearly evident in either case. In one case professionals felt intimidated and fearful of an adult in the family, it is also not clear what level of escalation or supervision sought to address this challenge.

9.1.7. Dependent on the level of intervention or planning this could be done in a variety of ways for example via professional or managerial supervision, or via a Child Protection Chair or Independent Reviewing Officer (IRO), if applicable to the case. In one of these cases, it is evident that a newly allocated IRO did outline that the plan was ineffective however this was relatively recently, and one would like to see escalation and oversight at a far earlier stage. It was expressed by the agencies forming the review panel that agency expectations of each other were not clearly defined leading to drift and a lack of decision making.

9.1.8. Of consideration in one of the cases is the Children and Young people's Complex Case Forum, established to ensure the CCG meet the Transforming Care requirements through the development and oversight of a "Dynamic Support Register". There is a requirement for Clinical Commissioning Groups (CCGs) to develop and maintain registers to identify people with a learning disability, autism or both who display, or are at risk of developing, behaviour that

challenges or mental health conditions who were most likely to be at risk of admission to specialist hospital or residential placement.

9.1.9. The scope of the complex case forum is largely across the Clinical Commissioning Group, health providers and Children's Services Oldham Council. it articulates that *"in some instances the team around the individual child or young person may be struggling to ensure the needs are appropriately met in order to achieve the best outcomes for a child or young person, despite deploying appropriate expertise, advice and resources. These cases, and any when despite standard escalation, there remains difference of opinion about responsibilities for the provision of expertise, advice or other resources which may impact upon arrangements, are reviewed by the Children and Young People Complex Needs Panel"*

9.1.10. The complex case forum is therefore part of a wider system of escalation, managerial supervision and formal case oversight and may have been helpful for at least one of these cases, particularly if the integrated commissioning of specialist interventions may have facilitated a solution to improve outcomes.

9.1.11. In terms of standard safeguarding practice, the opportunity for a distinct strategy meeting to consider HSB was missed in both cases, thus this thematic review considers that this is an area that requires some development. This will be addressed under **Key Finding 1 (Framework and Pathways**).

9.2. **ToR: How did agencies recognise and respond to the growing awareness of HSB and;**

- **What multi-agency approaches do the partnership utilise to plan and share relevant information when there is a concern about HSB?**
- **How well are additional vulnerability factors recognised and addressed in assessments, interventions, and plans.**

9.2.1. Published case reviews show that professionals can find it difficult to respond to the safeguarding implications of HSB. There may be several children involved, each of whom will have different needs, and minimising the immediate effects of an incident can become a priority. Because of this, professionals can find themselves managing individual episodes rather than looking at the bigger picture.

9.2.2. It is the view of this review that this is a relevant learning point, it was reflected by panel members and practitioners that multiple people were concerned about HSB but did not feel confident to respond in the right way. It was recognised that due to the number of other concerns in both cases it was not identified as an increasingly concerning issue that warranted a particular/ specialist approach to be taken.

9.2.3. Trying to coordinate the multifaceted complexity in both cases resulted in responses to individual incidents of HSB rather than the overall picture, the patterns of behaviour and the reasons behind it. It is clear that there was recognition of HSB however it is less clear to conclude whether professionals in both these cases understood the seriousness of HSB and the required response. Additionally, due to the complexity of both cases, large family settings, multiple siblings and confusion about who needed protecting, appropriate support and protection was not given.

9.2.4. The panel members and practitioners reflected that in these cases and others there are often multiple and chaotic family settings that professionals found difficult to get a baseline on. This is borne out in the research.

9.2.5. In terms of additional vulnerability, many children and young people who display HSB have experienced abuse or trauma (Hackett et al, 2013). In addition, young learning disabled people

with harmful sexual behaviours are a particularly vulnerable and neglected group and may need discrete intervention responses.

9.2.6. It is not evident that additional vulnerability factors were recognised and taken into account when responding to the issues of HSB, instead of this increasing the level of risk, assessments and multi-agency working it appeared to cause more confusion and professionals did not know where or how to focus their planning.

9.2.7. It was considered that the response may be different against a backdrop of wider complexity and existing vulnerability, despite the understanding that this is often the case when managing HSB. The result being that the response became confused, not coherent and there was an element of normalising the behaviour in the context of the additional needs (in these cases learning disability, communication barriers and family complexity).

9.2.8. The practitioner event identified the following perceptions of barriers within HSB:

- An absence or reluctance to use professional curiosity
- Cultural competence such as language barriers and the use of appropriate interpreters
- Single agency tunnel vision rather than multi professional working
- No recognised framework that is well understood and embedded in Oldham.
- Misconceptions about HSB
- Reluctance of professionals to talk about sexuality and to be clear and direct with young people and families when conveying messages
- A gap in knowledge across the workforce about HBS
- So much complexity that professionals could not “see the wood for the trees”.
- Lack of consistency of worker and in particular the Lead Professional
- A reliance on Children’s Social Care, over reliance on making “referrals”.
- Thinking that HSB is a normal presentation with children with Learning Disabilities- normalising behaviours rather than risk formulation
- Unclear recognition, pathways and shared decision making
- Confusion over thresholds- criminal consequences long term implications for the young person
- Variance in what’s available in the way of commissioned services and training on HSB

9.2.9. The role of the Lead professional was considered and generally it appeared that the perception was that this should be the Social Worker. The reviewer has considered the role of the Lead Professional.

9.2.10. The role of the lead professionals is to enable coordination of a package of support, to reduce overlap and inconsistency, consider the effectiveness and progress and to act as a point of contact with a child, young person or family. In any form of safeguarding this is a crucial role.

9.2.11. There are different considerations to consider when identifying a lead. Depending on the level of intervention, there may be a clear statutory responsibility to lead on work but there are several other considerations such as the level of trust, skills, ability and capacity as well as a number of other factors. The person who takes on the role of Lead Professional will vary according to the specific needs of the child and family.

9.2.12. A lead professional should be agreed across the agencies depending on the unique circumstances of any one case, but it should be recognised that identification of this role should be considered by agencies and does not always have to be a Children’s Social Worker **(Key finding 2- Lead Professional).**

9.2.13. Best practice identifies that professionals working with children and young people who display HSB should use a mix of both specialist risk assessment tools for HSB and more generic

assessment models. They should consider each child's developmental history, family background and any broader child protection concerns[v]. Panel members and practitioners were not confident that the workforce would be aware of the tools and models that they should be using.

9.2.14. It was identified that OSCP have to date used the Brook Traffic Light Tool to aid practitioners but that there is currently a block to using this due to the additional training and licence requirements introduced by Brook. Therefore, there is not a clear pathway that all practitioners are confident in using (key finding 1).

9.2.15. Consideration of assessment tools and pathways prompted discussion about what to do post assessment. The right assessment is essential, but it needs to lead to an intervention to reduce harm. In these cases, it has been established that despite different assessments including AIM, there was drift and they didn't inform the right intervention in a timely manner.

9.2.16. In summary the panel identified that there was not clarity of the agreed multi-agency approaches to HSB and did not feel confident that the workforce would know how to effectively respond. The practitioner event expanded on this line of enquiry and concluded that there is not a clear pathway, tool, or training to aid practitioners **(Key Finding 3- Workforce development)**

9.3. ToR: What do family members say about the effectiveness of agency involvement? Which services made a positive difference and what could have been better?

9.4. Whilst it was the ambition and the plan for this review to thoroughly explore a range of issues with family members, due to the ongoing real time management of these cases and parallel processes, unfortunately it has not been possible to facilitate this. As a result, we are not able to get a full understanding of this ToR.

9.5. By way of mitigation there have been extensive discussions with the identified Social Workers for both young people and this overview was provided earlier in the review.

9.6. We have some insight into the views of the family members albeit a narrow view.

9.7. ToR: Did the agencies hear, listen to, and respond to the voice of the young person?

9.7.1. In the cases considered for this thematic review there was opportunity to meaningfully engage with the subject(s) and with siblings and other young people as well as family members. Often the accounts given by different people were contradictory and confusing, the importance of understanding this was paramount in these cases.

9.7.2. It is essential to consider family or social factors that may contribute to the child or young person's harmful sexual behaviour, particularly if there is evidence of abuse within the family and to think about the impact a child or young person's harmful sexual behaviour may have on all family members.[vi]

9.7.3. In both these cases there was concern that the person at the receiving end of the harmful sexual behaviour was another child within the family and so it was essential to provide support for the whole family. This review found that there was not enough emphasis on the harm and risk for the siblings at an early enough stage.

9.7.4. Research was considered, in particular the view that children and young people who display HSB may have complex needs and may display other behavioural problems alongside their

HSB.[vii] This was true of both cases considered and thus could be concluded that this is not unique to these instances.

9.7.5. For example, children who display harmful sexual behaviour may:

- have poor self-regulation and coping skills
- experience social anxiety and a sense of social inadequacy
- have poorly internalised rules for social behaviour
- have a poorly developed sense of morality
- lack secure and confident attachments to others
- have limited self-control and act out emotional experiences through negative or otherwise inappropriate behaviour
- have little insight into the feelings and needs of others or their own mental states
- place their own needs and feelings ahead of the needs and feelings of others
- show a poorly defined sense of personal boundaries
- have developed strong and not easily corrected cognitive distortions about others, themselves, and the world they share
- have deficits in social skills and in social competence overall

9.7.6. One of the cases considered in this thematic review identified a young person who was profoundly deaf and therefore there was a significant communication barrier, it is not clear to what extent this was considered when formulating plans.

9.7.7. In the other case there was significantly low cognitive function and an identified memory limitation, additionally the AIMS assessment had identified that he was not able to understand another person's perspective. It is also not clear to what extent this was considered when formulating plans

9.7.8. These are both examples where the voice of either young person was not evident in multi-agency case planning.

9.7.9. In cases such as these, multi-agency assessment and planning should have been seen as essential. It would have facilitated the exchange of information, for example with respect to strategies for communication and if there was a barrier to communication this should and could have been addressed by getting all the agencies together to understand how it could be overcome.

9.7.10. Analysis of this ToR acknowledges that there were barriers in working with the young people, their siblings and wider family that impacted on their voice being heard and consequently on robust planning and coordination.

9.7.11. The reviewer did not get a sense from the information, panel meetings or practitioner events of the voice of the young people in this instance. This prompted consideration that a lack of knowledge and understanding of HSB together with the absence of clear frameworks, tools and access to specialist assessments may have resulted in less than ideal engagement with the young people and their families. **(Key Finding 4- communication issues)**

9.8. ToR: Were the assessments, interventions and plans culturally informed?

9.8.1. The panel and the practitioner event considered whether there was a concern about cultural competence that contributed to insufficient response. There are two factors there appeared to be of significance.

9.8.2. The first factor was that of language, and in particular with interpreting services.

9.8.3. The second factor was the large and complex family dynamics.

9.8.4. The research considers a range of complex factors that need to be considered in responses to BME young people with harmful sexual behaviours, including questions of language, culture, ethnicity of the worker, religion and spirituality. However, while such issues may be important, they must not be allowed to compromise or distract practitioners' attention from the primary focus of protecting children from harmful sexual behaviours.[viii]

9.8.5. Taking the first factor into account, it was evident that there had been some challenges in terms of communicating to non-English speaking family members. One interpreter voiced that she had felt very uncomfortable translating very explicit information. This prompted a discussion about the need to have specially trained interpreters who would have a knowledge base around HSB and who would feel confident to translate difficult messages.

9.8.6. The panel considered whether the cultural background of the families had resulted in a different direction of travel in terms of decision making and response to HSB. It was identified that there had been an over reliance on wider family networks to make decisions and safety plan at home rather than assessment and risk formulation.

9.8.7. This is not necessarily attributed to a cultural assumption though. Although the language issue has been established as a barrier, the panel felt that it was the large and complex nature of the families rather than their cultural background that changed the response.

9.8.8. Not fully understating a family's belief system and the level to which cultural competence is demonstrated is difficult to establish. The review finds no distinct evidence about the family's belief system having any significance on the way the cases were managed.

9.8.9. The panel and practitioners agreed that consideration should have been given to the method of communication and this is something that should always be considered when engaging with young people and their families **(Key finding 4).**

9.8.10. The panel considered that regardless of culture, neither family understood what was being communicated to them or what was being asked of them. This may be due to interpretation issues or because it was not communicated in a way that facilitated a full understanding.

9.8.11. In one case we have established that there was a particular problem with professionals and family being very fearful of a dominant male in the family, this was also a barrier to working effectively. This person diverted professionals away from important conversations with the young people and other adults in the household. This prompts consideration of risk assessment, escalation and supervision.

9.8.12. There is no evidence to confirm that assumptions were made because of the cultural background. It is the conclusion of this review that the insufficient engagement with the young people, siblings or their families was due to an overarching lack of understanding around HSB, plus the communication barriers and the dominant male rather than being related to a lack of competence around cultural background.

9.8.13. Little specific research has been conducted into the most effective ways of intervening with families of children and young people with sexual behaviour problems, although there is now widespread agreement that family intervention is important. Working with the carers and parents of children and young people who have displayed harmful sexual behaviour should be seen as a central part of assessment and intervention **(Key finding 1).**

9.9. ToR: Are any changes to the local safeguarding arrangements required as a result of the learning from this thematic review?

9.9.1. The previous ToR have identified several key findings that will be summarised presently. The review has considered the current safeguarding arrangements and the role of the Oldham Safeguarding Children Partnership.

9.9.2. We know from research and experience that information about children who display HSB should be shared between agencies so that professionals can get an overview of the child's situation and identify any risks they are exposed to. Additionally, that professionals working together need to be clear about their individual roles and how this contributes to the overall safeguarding of the children involved. We have identified that professionals felt ill equipped in both knowledge and tools to effectively manage HSB from a single agency and multi-agency perspective.

9.9.3. The panel members raised questions about the capacity of services and ease of access to appropriate specialist assessment when indicated. The understanding of how accessible this is in Oldham varied from the perspectives of the panel members and practitioners. Therefore, it could be concluded that there is a lack of clarity in terms of what can be accessed and how one would access it.

9.9.4. Clarity in partnership approaches and workforce development was repeatedly identified as an area of concern **(Key Finding 1 and 3).**

9.9.5. There is an opportunity to consider the partnership approaches and agree a framework, pathway and workforce development programme for HSB **(Key Finding 5, commissioning a multi-agency response to HSB).**

10. Key Findings

10.1. Key Finding 1: Frameworks and pathways:

10.1.1. The reviews finds that there is lack of clarity on the agreed approaches to HSB and therefore frameworks and pathways for HSB in Oldham should be reviewed and developed.

10.1.2. Although the research into HSB is still limited, there are some excellent guidelines, frameworks and tools that can adopted and utilised.

10.1.3. The Nice Guideline[ix]promotes multi-agency approaches, continuity of care, collaboration with specialists particularly if there are additional or complex needs. This can be considered alongside the Harmful Sexual Behaviour framework[x] to develop a consistent multi agency response to children who display harmful sexual behaviour.

10.2. Key Finding 2, Lead Professional:

10.2.1. This review finds that there was not a coordinated response to either the existing safeguarding issues or the HSB concern. Additionally, that there is not a common understanding of the role of “Lead professional” and the value that this adds to effective management of not only HSB but safeguarding.

10.2.2. We know from practice that children and families who require support from a range of specialist professionals can potentially receive fragmented and uncoordinated services and thus appointing a Lead Professional at the earliest point is central to the effective frontline delivery of services for children with a range of additional needs.

10.2.3. It is important to note that in some circumstances the Lead Professional may need to be allocated in line with statutory guidance where child protection processes are in place. However, as this review is a thematic review, the scope of HSB will be vast and each case should consider the overall coordination and the identification of the best placed Lead Professional.

10.3. **Key finding 3: Workforce development:**

10.3.1. The review has found that there is a lack of confidence across the workforce in Oldham about pathways for HSB. It was identified that this was in part due to frameworks and pathways not being clear but also an area for development in terms of knowledge and understanding of HSB.

10.3.2. Therefore, the level of awareness could be further raised to improve early identification of children in need of support. Additionally, to upskill practitioners and carers who may not necessarily have the knowledge and skills for working directly with children displaying HSB.

10.3.3. This is not unique to Oldham, Research in Practice (2016) considered the workforce perspectives on HSB and made recommendations to strengthen understanding by embedding peer supervision and team-based learning, strengthening support through reflective supervision, provision of specific training and skills development for those working with children displaying HSB and improved general awareness on HSB.[xi]

10.3.4. Consideration of a multi-agency supervision pathway to facilitate the more complex cases which may need more specialist approaches or particular commissioning arrangements would align well to the findings of this thematic review.

10.3.5. The recent Ofsted review into sexual abuse in schools and colleges identified a gap in knowledge and awareness that should also be considered alongside this thematic review.

10.4. **Key finding 4, Communication Strategy:**

10.4.1. The review identifies several elements with communication.

10.4.2. The method of communication with non-English speaking family members was not adequate and consideration of the use of relevantly trained interpreters should be considered (this may not be unique to the specific subject of HSB).

10.4.3. One of the cases considered for this thematic review concerned a profoundly deaf young person, consideration of communication methods to understand and interpret difficult information should be considered (this may not be unique to the specific subject of HSB).

10.4.4. The voice of the child, young person was not evident in the cases considered and this should be reflected in workforce development plan.

10.4.5. It is established by the panel that Oldham has already got assurance that there is access to appropriate systems and processes for interpreting services and thus the finding is more specifically about how effective communication strategies are embedded into practice from an early point in case management.

10.5. **Key finding 5- commissioning a multi-agency response to HSB:**

10.5.1. It is one of the findings of this review that there is not a sound understanding of the multi-agency response that is commissioned in Oldham, what outcomes this focuses on and how its effectiveness is measured.

11. Conclusions

11.1. Whilst the subject matter of the thematic review focused on harmful sexual behaviour, there has been a focus on basic safeguarding practice. The review has highlighted that due to several factors, the basic practice did not provide a firm enough foundation to build on when more complex issues emerged. The emerging complexities created a chaotic environment that subsequently paralysed a coherent response.

11.2. Wider research together with findings from this review tell us that where there is HSB there is likely a wider set of complexities and vulnerabilities so these cases were not unique and any approaches to HSB should reflect that.

11.3. Changing sexual behaviour often requires the services of more than one agency, while effective risk management and support requires involvement from all the professionals involved with the young person and their family and carers. The landscape for responding and addressing harmful sexual behaviour is wide and complex. It spans several different systems and thus a coherent and coordinated approach is essential.

11.4. This review identifies significant efforts and persistent hard work of professionals to manage both the cases considered, however the lack of clarity to the approaches to be taken together with a requirement for workforce development hindered the pace of progress.

11.5. The review identifies some concerns in the understanding of the lead professional role and communication issues that are not unique to the area of HSB, instead could be applied to safeguarding principles as a whole.

11.6. Lastly the review recognises the specific and additional vulnerabilities of this cohort, the complexity and scale of the issue and most importantly the voice of the child and young person.

11.7. Recommendations are made for the Oldham Safeguarding Children Partnership to strengthen approaches to HSB in the context of this thematic review as well as national research.

12. Recommendations to the Partnership

12.1. **Arising from the analysis undertaken in this review and its findings it is recommended that the OSCP:**

Considers its frameworks and pathways for HSB to take into account: - A continuum of responses to children and young people displaying HSB aligned to the Continuum of Need. - Prevention, identification and early assessment. - Dynamic Risk management - Effective assessment and referral pathways - Interventions, access to specialist services. - Workforce development. - Addressing communication barriers.
Considers its approaches to multi-agency working in the context of the role of Lead Professional to include guidance for the workforce and: - Assurance of its effectiveness - Shared Risk management - Escalation processes both single agency and multi-agency - Managerial supervision - Multiagency supervision for complex cases - Coordination and decision making
Considers its communication strategy for working with children and families to ensure that there is effective weight given to barriers to communication and a plan embedded across all levels of the safeguarding continuum. This is not unique to HSB but good practice in all safeguarding practice.
Seeks reassurance from commissioning and provider organisations regarding impact of interventions and services on HSB including: - Review current offer and map against the pathway to identify gaps in interventions - Assurance of effectiveness. - Evidence of voice of the child, young person - Effectiveness of the Complex Needs panel in these two cases

13. Appendix 1, Mentimeter poll:

Menti - Sexual Harmful Behaviour -

14. References:

[i] 1 Chapter 4 of 'Working Together 2018 ' details the purpose of safeguarding reviews. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_To gether_to_Safeguard-Children.pd

[ii] Children and Young People with Harmful Sexual Behaviours: Research in Practice, Simon Hackett (2014)

[iii] Review of Sexual abuse in schools and colleges: OFSTED (2021)

[iv] Children and Young People with Harmful Sexual Behaviours: Research in Practice, Simon Hackett (2014)

[v]Hackett, S., Branigan, P., Holmes, D. (2019) Harmful Sexual Behaviour Framework: An evidence-informed operational framework for children and young people displaying harmful sexual behaviours. 2nd ed. London: NSPCC.

[vi] NICE G55 Harmful Sexual Behaviour among children and young people (2016)

[vii] Hollis, V. (2017) The profile of the children and young people accessing an NSPCC service for harmful sexual behaviour: summary report. [London]: NSPCC.

[viii] Children and Young People with Harmful Sexual Behaviours: Research in Practice, Simon Hackett (2014)

[ix] NICE G55 Harmful Sexual Behaviour among children and young people (2016)

[x] Hackett, S., Branigan, P., Holmes, D. (2019) Harmful Sexual Behaviour Framework: An evidence-informed operational framework for children and young people displaying harmful sexual behaviours. 2nd ed. London: NSPCC

[xi] Research in Practice (2016) Workforce perspectives on harmful sexual behaviour Findings from the Local Authorities Research Consortium