North Yorkshire
Safeguarding Children Partnership

7 point briefing

Multi-Agency Deep Dive Audit into

Harmful Sexual Behaviour Cases

June 2020

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Summary

North Yorkshire Safeguarding Children Partnership (NYSCP) carried out a deep dive multi-agency audit into four cases where Harmful Sexual Behaviour (HSB) was a factor within North Yorkshire. The audit considered cases involving young people who were currently or had recently been open to Children and Family Services (CFS). This included 1 x Child supported on a Child Protection Plan, 2 x Children supported through Child in Need (1 had recently closed to CFS) and 1 x Child who was Looked After.

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What is Harmful Sexual Behaviour?

The definition of Harmful Sexual Behaviour used within this audit is taken from the NSPCC definition:

> *One or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. It includes using sexually explicit words or phrases; inappropriate touching; using sexual violence or threats to full penetrative sex with other children or adults. Children and young people who develop harmful sexual behaviours harm themselves and others'* (Hollis & Belton, 2017).

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What did the audit find – areas working well?

- Quality of Recognition – overall HSB was recognised well by agencies, appropriate referrals were submitted at the right time. Good practice was seen by the Youth Justice Service being included at an early point of consultation and/or invited to strategy meetings to enable good links between the child, their family and the criminal justice process.
- Quality of Assessment – cases characterised strong systemic practice to understand the child's early Adverse Childhood Experiences (ACES), risks and historical patterns of behaviour (e.g. use of family networks and genograms) were positive in enabling a holistic understanding of the child's experiences. The audit found positive examples of practitioners having skilled difficult conversations with both the child and their family about the risk of their thoughts/behaviours; whilst being cognisant and empathetic to the child's wellbeing. Appropriate referrals to other agencies such as Forensic Child Adolescence Mental Health Services (CAMHS) to provide advice and support regarding risk assessment and risk management was also positive, as well as early referrals to the Child Sexual Assault Assessment Centre (CSAAC).
- Use of the Under 10 Protocol – the use of the Under 10 Protocol by North Yorkshire Police enabled early liaison with the Crown Prosecution Service (CPS), the expedition of digital forensic examinations and review by a CPS Rape and Serious Sexual Offence (RASSO) Gatekeeper within an 8-week window to reduce the impact on the child caused by investigation delays.
- Joint Working – cases that had a clear multi-agency plan for the child and their family and a good understanding of what intervention was to take place were evidenced within this cohort. There was evidence that in a number of cases of a common multi-agency sense of purpose and co-ordinated plan. For example, the sharing of information with a child's GP Practice so they could put appropriate measures in place to enable the child to adhere to their bail conditions whilst attending regularly at the surgery. Similarly, where cases used the AIMS2 assessment, this was well shared with agencies.

What did the audit find – areas for development?

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- Disguised Compliance – was identified as a feature within families in some of the cases. This was often compounded by features such as previous victimisation in parents, intergenerational familial sexual abuse, fear, shame, lack of recognition of risk posed to the child and wider circles. However, if not robustly approached by professionals can result in delays for the child in progressing any criminal investigations, accessing appropriate therapeutic support and provision, longevity of bail conditions where there is not always confidence across the multi-agency that family members can safely manage the risk a child poses etc.
- Timeliness of Intervention – In some cases, interventions were hindered by long criminal investigations, awaiting the outcome of these resulted in delays in starting AIMS2 assessments, bail conditions limiting contact with families and increasing social isolation experienced by the child. On occasions, professionals appeared to experience a sense of 'impasse' at what intervention could begin prior to the outcome of the criminal investigation. Recognising the need to hold strategy meetings and ensuring the right professionals were involved from the start often mitigated this impact.
- Access to therapeutic support for children who have been sexually abused – Early signs of sexualised behaviour were often evident in primary school, albeit not specifically addressed until the child became older and the behaviours escalated. Access to specialist therapeutic provision for children who had been victim of child sexual abuse was felt to be needed to try to address the trauma that may later lead to children displaying harmful sexual behaviour themselves. Greater understanding is required as to what the service provision in North Yorkshire looks like, as often families were required to travel out of the county often hundreds of miles to access help. This was both costly and logistically difficult resulting in support in some cases not being accessed.
- Complex Case Management – In highly complex cases, professionals were responding regularly to periods of crisis, however this sometimes resulted in the planning and intervention around the specific harmful sexual behaviour to be overshadowed. This can be made more complex in cases that are managed through a number of different processes e.g. RAISE (Risk, Analysis, Intervention, Support and Innovation), No Wrong Door, Multi-Agency Child Exploitation (MACE), Looked After Child Reviews as well as more latterly in one case Multi-Agency Public Protection Arrangements (MAPPA).

What will NYSCP do with these findings?

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NYSCP to disseminate information in relation to:

- NYSCP will review their Harmful Sexual Behaviour Practice Guidance and One Minute Guide regarding the AIMS 2 assessment to increase partnership understanding and awareness.
- In partnership with the Office of the Police, Fire and Crime Commissioner, NYSCP will review the current service provision for children who have either perpetrated or been victim to sexual abuse across North Yorkshire to establish if there is sufficient provision or gaps in commissioning.
- NYSCP will promote the Child Sexual Assault Assessment Centre (CSAAC) across North Yorkshire promoting that children accused of sexual offences can also be referred. A One Minute Guide will be created to circulate across the partnership.
- The NYSCP Learning and Development Subgroup will consider options for addressing the issue of Disguised Compliance across the partnership.

Next steps

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- All agencies involved in the audit will feedback specific good practice and areas for development identified for their service during the audit day discussion.
- The findings of the deep dive audit into Harmful Sexual Behaviour will be shared with the NYSCP Learning and Improvement Subgroup who will agree and adopt identified actions onto the subgroup's overarching action plan to seek assurance learning from the audit is implemented and monitored.

Resources

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There are a range of national and local resources and guidance which can support professionals in relation to preventing and supporting children who are displaying harmful sexual behaviour.

- North Yorkshire Practice Guidance via the NYSCP website
- NSPCC guidance via the NSPCC website.

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