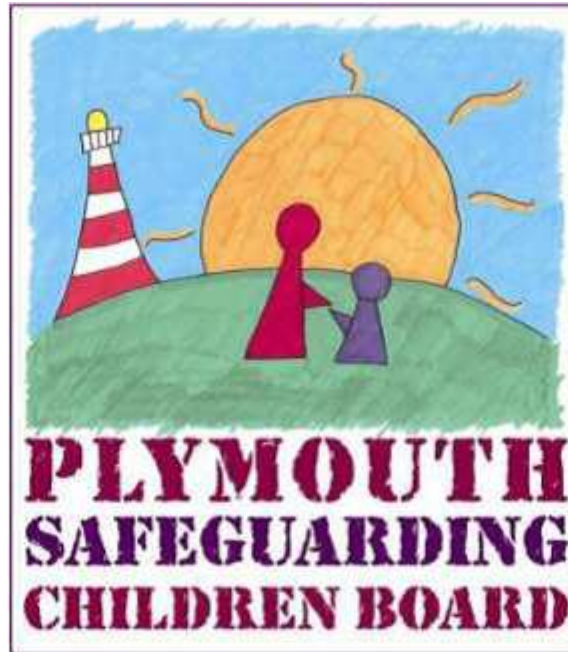

PLYMOUTH SAFEGUARDING CHILDREN BOARD

Serious Case Review

Child WR

Independent Reviewer: Mark Dalton

1. INTRODUCTION

1.1 Child WR is subject of this review following his conviction of a number of sexual assaults against younger children. Child WR was found guilty and received a custodial sentence. Throughout this review the child will be referred to as Child WR.

1.2 Child WR was involved with multiple agencies through his childhood and was known to services. Child WR's history was complex and he had additional needs which would add to his challenges for him and the wider family.

1.3 The purpose of this document is to provide an overview of the outcomes and recommendations of the serious case review commissioned by Plymouth's Safeguarding Children Board into a serious incident involving a child.

1.4 The aim of a Serious Case Review is not to assign blame, but to ensure that lessons are learned, and recommendations are made to the agencies involved in order to avoid similar situations in the future.

1.5 In the interest of confidentiality names will not be used in this document. Instead an individual's title or position they held will be cited, for example mother, child or Children's Social Care services, police etc.

1.6 The Serious Case Review (SCR) was commissioned by the Chair of the Plymouth Safeguarding Children Board on 12 December 2018. Following the Serious Case Review authored by Mark Dalton Plymouth Safeguarding Children's Board has determined it would be most useful to publish this Executive Review regarding the considerations being put forward to agencies from this review as learning.

1.7 The statutory guidance on Serious Case Reviews has substantially changed since this report was commissioned. For further information about Serious Case Reviews please refer to the "Working Together to Safeguard Children" document published by the Department of Education (DfE).

1.8 This Executive Review focuses on two key areas of practice. Firstly the management of a young person with a number of behavioural and learning difficulties. Secondly the response to and management of harmful sexual behaviour displayed by Child WR.

2. ANONYMISATION

2.1 Child WR's family and the victims of the sexual assault remain living in their communities. Therefore, as far as possible, identifying details have been removed from this report and events which may lead to identification of any individual summarised.

3. THE SERIOUS CASE REVIEW PROCESS AND TERMS OF REFERENCE

3.1 The purpose of the Serious Case Review is:

a. To examine openly and critically individual agency practice in order to establish whether there are lessons to be learnt about the way that local professionals and organisations work together to safeguard children and promote their welfare.

b. To identify what those lessons are, and how they will be acted on and what is expected to change as a result.

c. To determine what actions may be needed or improvements in inter agency working in order to better promote and safeguard the well-being of children and young people.

3.2 The Independent Chair of the Plymouth Children Safeguarding Board is Andy Bickley. The Serious Case Review Panel is chaired by DCI Bentley an Independent Chairperson, and made up of representatives from the following the agencies:

a. Designated Nurse for Safeguarding Children
b. Designated Doctor for Safeguarding Children
c. Detective Chief Inspector, Devon and Cornwall Constabulary
d. Safeguarding Service Manager, Children's Social Care
e. Principal Educational Psychologist
f. Any other seconded member as appropriate.

3.3 Each agency that was involved at the time of the incident, or had been, involved with members of the family in the past, was asked to complete a chronology and an Individual Management Report.

3.4 In order to understand the family context the Individual Management Report authors were to consider all historical information held by their agency and produce a full summary of any significant factors to inform the Individual Management Report.

3.5 The serious case review is focused on the two years prior to the offence which saw Child WR convicted. There is also a consideration of other information which may support this review and agencies contributed as follows:

a. Devon and Cornwall Police

b. Plymouth City Council –SEND (Special Educational Needs and Disabilities Services)

c. Plymouth City Council – Children's Integrated Disability Team/ Children's' Social Care

d. Livewell South West –CAMHS (Child and Adolescent Mental Health Services).

e. Plymouth Psychology Service

f. Youth Offending Team

g. Education (Primary and Secondary School for WR)

h. NSPCC.

3.6 Child WR and members of his family met with the lead reviewer and discussed the events leading up to this review. Their contributions are included in this review where relevant.

3.7 An Independent Overview Report Author, Mark Dalton, was commissioned to provide a report based on the Individual Management Reports, to include an analysis of single agency and multi-agency working, identifying and making recommendations from the lessons learned from the review. Although independent of the Panel, the author met

and liaised with the panel members throughout the process to discuss the progress and implications of the review.

4. BRIEF CASE HISTORY

4.1 Child WR lived with his maternal grandparents since infancy. His birth mother recognised that she was unable to care for him and has played no part in his upbringing. Child WR's grandparents have provided a secure and nurturing home and have worked to adapt to his needs and cope with the ever-increasing challenges posed by his behaviour as he has grown up.

4.2 WR experienced additional challenges with a diagnosis of Foetal Alcohol Spectrum Disorder (FASD); Attention Deficit Disorder (ADHD) and Autistic Spectrum Disorder (ASD). Behaviourally FASD and ADHD can look very similar, particularly in respect of limited attention, impulsiveness and being physically active. A further diagnosis of Mild Learning Disability (MLD) was made at the time Child WR was first placed in a Special School.

4.3 WR was a patient of the Child and Adolescent Mental Health Service (in Plymouth this service is known as Livewell South West) who prescribed medication to help regulate his behaviour and gave advice to his grandparents about managing his behaviour.

4.4 Child WR has attended Special Schools since Year 1. His educational needs have been met throughout his school career by local Special Schools. His needs have been regularly assessed and responded to; additional funding for extra staff has been provided and additional security measures taken at school to prevent him absconding.

4.5 Over a period of 3 years nearly 50 missing episodes were reported to the Police. There were others which were not reported and where the family members would search for WR.

4.6 Child WR's social and educational progress was limited. He is described as highly volatile and impulsive and would react against the imposition of boundaries and attempts to control his behaviour with little concept of personal risk. This behaviour was exhibited at home, in the community and school.

4.7 Police records show a significant level of concerns reported to them about Child WR's behaviour from a young age. The majority of these involved minor thefts and anti-social behaviour. There was a recognition from the Police and many of his victims that Child WR had a disability, and a degree of leniency was shown.

5. CHILD WR'S DAY-TO-DAY EXPERIENCE.

5.1 Child WR had the benefit of a secure and loving home environment that provided unconditional love and support to him.

5.2 He had a secure attachment to his grandparents and his grandmother in particular. His grandparents had a good understanding of his needs and were conscientious in taking him to medical appointments and other meetings.

5.3 Although Child WR was the focus of their concern it should be remembered that he was not the only child in the house and was part of a much larger extended family who

were in regular contact. Child WR has an older sibling and there is a close bond between them.

5.4 Child WR had a circle of friends at school and in the community. Because of his ‘daredevil spirit’ his grandparents were concerned that he may end up being a scapegoat for older boys who would dare him to do something. Their greatest fear was that he would become involved in drugs or would be beaten up. Child WR had no concept of time, and sometimes his failure to return home – which would be reported as a missing episode – may equally have been a lack of awareness on the part of Child WR of how long he had been absent.

5.5 School describe him as being a “bundle of energy” with “incredible” acrobatic skills, physically able and strong for his age. The main concerns for grandparents and school was Child WR’s impulsivity and lack of awareness of the consequences of his actions. In reviewing the composite chronology of agency involvement, it would seem that very few weeks were incident free.

5.6 School provided a structured experience for Child WR, although there is no evidence that this had a positive effect on his impulsivity or self-control. This is not to diminish its importance – school was a controlled environment where Child WR could interact safely with his peers and a “normal” experience for a young person who was often denied those opportunities because of the extremes of his behaviour. It also provided a period of daily respite for his grandparents. Child WR enjoyed school and was well liked by his teachers who were committed to adapting the school environment to meet his needs and respond to the changing demands to prevent him absconding and keep him safe.

5.7 Grandparents have reported that it was difficult to dissuade Child WR from doing something once he had made up his mind – and increasingly difficult to physically stop him as he became older and more physically able. They found the best tactic was to try and distract him and get him interested in something else rather than forbid him to do anything. They would also make the point that he could be loving and caring towards his family and wanted to be helpful to his grandparents.

6. EVENTS LEADING TO SERIOUS CASE REVIEW

6.1 Child WR’s sexual offending occurred at the same time as other anti-social and low-level offending behaviour. The first reported offence occurred just prior to a Child Protection Strategy Meeting being convened because of concerns about Child WR. These were a culmination of concerns; an allegation of inappropriate sexual behaviour with another pupil at school, numerous reports of Child WR going missing and the unsuitable company he was keeping. At that time there was also thought to be a risk of Child Sexual Exploitation (CSE) although this proved to be unfounded. The decision to convene a Strategy Meeting also noted that there had been significant involvement from other services in the past which had not altered Child WR’s behaviour.

6.2 Child WR has been linked to 5 sexual assaults, most of which come to light following the investigation into the offences for which he was convicted. However, one offence which occurred six months earlier was being investigated at the time of the final sexual assault.

6.3 The sequence of the reporting of incidents of harmful sexual behaviour is significant and may partly explain why there was no recognition that Child WR may have been developing an unhealthy sexual interest, or any identification of an escalation in his behaviour. When the incidents are considered chronologically, they suggest a pattern of assaults which are becoming more serious and Child WR placing himself in situations where the opportunity to offend was more likely.

6.4 In chronological order the details of Child WR's harmful sexual behaviour are as follows:

First Incident.

6.5 The first allegation of a sexual offence committed by Child WR is likely to have occurred three years prior to the offence for which he was convicted. It was not reported at the time, but the parents of the victim eventually came forward prompted by the publicity surrounding Child WR's eventual conviction. It is alleged that Child WR attempted to sexually assault a younger child but was stopped by the victim's older sibling. The victim's family were new to the area and were persuaded not to report the incident to the Police by neighbours who were aware of some of Child WR's underlying problems.

Second Incident.

6.6 Eight months prior to the final offence Child WR admitted to inappropriate sexual behaviour with a peer from school. The incident was known to Child WR's grandparents and the school. It was reported to be consensual and no further action was taken.

Third Incident.

6.7 Five months prior to his conviction Child WR was reported to the Police for a sexual assault on a younger child.

6.8 At this time Child WR was an open case to Children's Social Care and a single assessment was being undertaken due to concerns about frequent missing episodes and being beyond his grandparents' control.

6.9 A Strategy Meeting had already been arranged to consider the risks to Child WR when this latest allegation of a sexual assault was made. The meeting concluded that Child WR required on-going support. He was not considered at significant risk of harm himself and a number of additional safety factors were identified; his Grandparents were working with a range of professionals. YOT were involved and NSPCC attended to provide expertise to the decision making regarding a further assessment around the on-going risk of further sexual assault. The strategy was reviewed three weeks later, and a decision made to continue offering support on a Child in Need basis.[1]

[1] "Child in Need"; Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:
- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a Local Authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is disabled.

6.10 A Police investigation was initiated, and Child WR was interviewed as a voluntary offender with his Grandmother as the appropriate adult. In interview he admitted straight away to the offence although he could not provide an explanation why he did this other than saying he had seen adults behaving in a similar way in public. Child WR apologised for what he had done and recognised it was wrong. It must be remembered that there had been no previous concerns about sexual assaults raised with the Police prior to this offence (although they were aware of the report of Child WR engaging in consensual sexualised activity with a same age child known from school).

6.11 The initial response to this incident was to view it as suitable for diversion by way of a caution (initially the victim's parent agreed with this, although they would later change their mind). Given the lack of agreement to a caution the case required the consent of a senior Police officer and CPS authority prior to a caution being administered.

6.12 A file was sent to CPS two months after the offence was committed. Three months later CPS requested further information about the work that had been undertaken by Children's Social Care with Child WR and his family, before deciding whether a caution was appropriate.

Fourth Incident.

6.13 A few days before CPS requested the additional information Child WR committed a sexual assault on a younger child. The incident took place at a local leisure centre and the victim was a member of a family group who had befriended Child WR because he was a classmate of one of their children. This assault was undetected at the time, and it is not known whether Child WR took any steps to keep the incident secret.

Fifth & Final Incident.

6.14 Two weeks after the previous incident Child WR had again joined the same family on an outing and it was noticed that he had disappeared with the same child. Child WR was discovered nearby in the act of committing a sexual assault and he ran away after being discovered. He was later arrested and admitted to sexual offences against the child.

7. LEARNING FROM OTHER SERIOUS CASE REVIEWS

7.1 Harmful sexual behaviour is cited as a cause for concern in a significant minority of cases held in the NSPCC National Serious Case Review Archive.[2]

7.2 In addition to the Plymouth case Child Q, published in 2015, there are common threads which resonate with the issues facing workers in Plymouth. The need to improve Strategy Meeting practice is a common theme. This is closely allied to the need for a greater understanding of the nature of harmful sexual behaviour. A common finding regarding Strategy Meetings is that they fail to obtain the full picture of concerns or undertake the initial analysis of risk.

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[2] 71 out of 1392 Serious Case Reviews cite harmful sexual behaviour as a theme of the review. The NSPCC also produce a briefing on the learning from serious case reviews where HSB has been a factor. Harmful sexual behaviour: learning from case reviews

7.3 The provision of services for children who display harmful sexual behaviour is inconsistent across the country and it is not coincidental that the majority of reviews where there have been concerns about harmful sexual behaviour had been undertaken in areas where there are no established services.

7.4 A less apparent theme, but still significant is the lack of resources for young people with a level of learning need. Research indicates that around 40% of young people referred to specialist HSB projects have some degree of learning need and are even less likely to receive a service.[3]

7.5 Clearly not every area will have the resources to develop a dedicated service, but through the introduction of specialist training, dedicated procedures and standardised assessment tools it is possible to develop a more consistent and informed approach to this area of practice.

7.6 An additional complication in this case is that Child WR was the perpetrator of the abuse and it is important not to conflate perpetrators and victims with special needs. It is widely recognised that children with a disability are particularly vulnerable to being abused[4]. The most recent triennial review of Serious Case Reviews suggests this figure is 10% of the total number of cases leading to Serous Case Reviews.

8. FINDINGS

8.1 The recognition of Child WR's level of disability determined the professional response to his offending behaviour across Children's Social Care, the Police and YOT. Although it was appropriate to show leniency towards him this had the unintended consequence of Child WR rarely facing any consequences for his actions.

8.2 It is important to consider whether the demands being made on the grandparents to supervise and control Child WR were reasonable and realistic. Whilst their commitment is not in question, as Child WR became older and more difficult to manage the expectation that his grandparents could provide the necessary safeguards became increasingly unrealistic.

8.3 The family's feedback to this review is that they found the system of support complicated and difficult to understand. A number of professionals entered their lives, and they invested their time and trust in building relationships only to find these workers left, usually with no discussion about what had been achieved or what would happen next.

8.4 The Strategy Meeting and follow-up meeting were missed opportunities to focus on Child WR's offending behaviour. It is noted that the meeting was initially called because of concerns about Child WR's risk-taking behaviour. Nonetheless the meeting looked at the third incident as a one-off event and concluded that further assessments were necessary; firstly, to ascertain whether Child WR should remain at home and secondly to assess whether it was possible to work with him therapeutically on his sexual behaviour problems.

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[3] Individual, Family and Abuse Characteristics of 700 British Child and Adolescent Sexual Abusers Child Abuse Review 27th February 2013

[4] Triennial Analysis of Serious Case Reviews 2011 - 2014. Pathways to Harm, pathways to Protection p70

8.5 This conclusion was a reasonable one in the context of what was known at the time. However, the conclusions of the meeting were recorded ambiguously with actions wrongly attributed to agencies which perpetuated delay and confusion. Some key professionals were unaware that the meeting had even taken place.

8.6 Several months before the fifth and final incident there was sufficient evidence to consider whether Child WR needed a specialist residential resource that could care for him safely and also work on his sexual behaviour problems This conclusion was supported by the NSPCC who agreed that a therapeutic intervention would be beneficial, but that Child WR needed a stable and secure placement to do so. This seems to have been interpreted as a need to offer further support to the family rather than consider an alternative. It would seem that other agencies were under the impression that this NSPCC assessment would lead to a referral being accepted by the local NSPCC Service Centre to undertake direct work with Child WR. However, this was not the case (and from the perspective of the NSPCC was never an option). In fact their assessment was that an alternative placement was needed and the wider behavioural concerns addressed before any work could be attempted.

8.7 This is not to say that it would have been easy to find a suitable residential establishment that could keep Child WR safe and also meet his therapeutic needs. His family would also have resisted Child WR being placed in a residential establishment on a voluntary basis. There are probably less than six establishments in the UK which could meet Child WR's needs, during the period under review it would have been the responsibility of the allocated Social Worker to try and identify the most suitable.

8.8 In the case of Child WR the Police were required to obtain CPS authority to proceed with a caution given the seriousness of the third incident and the views of the victim's mother. The CPS took three months to reply, and their next contact was a request for information about the social care interventions with Child WR. Ultimately the CPS never reached the final decision about the caution before Child WR committed further serious sexual offences. The effect of this delay was to inhibit progress regarding work on Child WR's sexual offending, although this may not have materially affected the services offered him or provided any additional safeguards. However, the fact remains that agencies were in limbo awaiting the CPS decision and the subsequent delay had a negative effect on case planning.

8.9 It is important to note that since the events described in this review a regional Forensic CAMHS service has been established[5] which could provide the specialist advice and guidance which professionals were struggling to identify.

9. LEARNING

9.1 There is a need to place greater focus on risk management with young people such as Child WR where there are multiple challenges of the young person's behaviour and their complex needs.

9.2 Children and young people's missing episodes need to be considered within the context of all known risks. Some of the interventions offered for Child WR inadvertently ignored the complexity of his needs by focusing on one aspect of his

[5] Forensic CAMHS (FCAMHS) South West (South)

behaviour rather than considering his needs in the round. WR was highly vulnerable as evidenced by his early links to low level offending, failure to return home and association with known adults who would pose a risk through their own links to drug misuse and sexual offending. The risk posed to Child WR from these external sources must be fully considered for fully effective risk management.

9.3 There needs to be consideration with family members who are managing risk. Family members need clear support and need to be given clear instruction and guidance on risk management. This needs to be clearly set out by professionals supporting the family and consistent messages given by all agencies.

9.4 Effective assessment and decision making require a thorough understanding of the historical context within which current events and behaviours occur. It is essential that those making judgements should have access to and make full use of relevant existing case material from the agencies involved with the young person.

9.5 Strategy Meetings can be particularly important in cases of harmful sexual behaviour. Ideally the Strategy Meeting is an opportunity to get a full account of the incidents causing concern and any antecedents, consider the needs of all the children involved in the incident and enable an initial risk assessment and safety plan. This level of shared understanding is also important for engaging parents and carers and they are much more likely to support intervention if they are contacted soon after the incident comes to light.

9.6 Participants in this review have commented on the lack of resources for children and young people below the threshold for prosecution and in particular the lack of resources for children and young people with a disability. Children and young people with learning disabilities are more vulnerable both to sexual abuse and to displaying problematic sexual behaviour. In one large UK study, 38% of those referred to specialist services because of HSB were assessed as having a learning disability[6].

9.7 Child at risk alerts (CARA) are email reports routinely generated by the Police and distributed to all agencies, usually to a generic hub rather than named individuals. There is the potential for CARA to become a more effective information sharing tool than it is at present. If alerts can be posted more quickly, dissemination can be expanded to include all relevant agencies and for agencies to devise a system to ensure that allocated workers receive notification of an alert.

10. CONSIDERATIONS

10.1 The following considerations include those made in the Individual Management Reports and by the Overview Report author. These recommendations are all subject to an Action Plan, which will be monitored by Plymouth Safeguarding Children Board to ensure that they are fully implemented.

Overview Report Author: Mr Mark Dalton
Plymouth Safeguarding Children Board

[6] In one large UK study, 38% of those referred to specialist services because of HSB were assessed as having a learning disability. Hackett, S., Phillips, J., Masson, H. and Balfe, M. (2013) Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. Child Abuse Review, 22(4)

Considerations

Consideration One
Police

The use of Child at Risk Alerts (CARA) should be reviewed with the aim of producing the following improvements:

- timeliness of notifications being added to the alert system by the Police;
- all agencies to review how they receive notifications and disseminate them to relevant staff;
- CARAs to be sent to the Youth Offending Team, Children's Disability Team and other relevant professionals involved in a particular case;
- introduction of an agreed multi-agency review protocol; where an agreed number of alerts about the same child within a set time period trigger a multi-agency review.

Consideration Two
Children's Social Care (Including Integrated Services)

Strategy Meetings:
The agreed procedure for Strategy Meetings should be reviewed to emphasise:

- agency representation from any key professional who has knowledge of current risks to the young person and their needs;
- the circulation of minutes with agreed actions/action points within an 24 hour timescale;
- evidence of risk assessment/safety planning to be recorded as part of the Strategy Meeting.

Professional understanding of foetal alcohol syndrome and its impact
To improve the level of knowledge across the Children, Young People and Families workforce has a clear understanding of the signs, symptoms and impact of Foetal alcohol issues. This must be integrated into core safeguarding training. In addition, links to organisations that have expertise in foetal alcohol syndrome must be used (such as the FASD Network UK alongside local support groups).

Risk management within family settings

When working with families where there is a high level of risk, consideration should be given to the following to ensure safe management and timely outcomes for the young person concerned:

- clear risk management planning which is SMART and outcome focussed to ensure a timely, appropriate response with named leads responsible for key intervention required;
- each risk management plan will be reviewed on a frequent basis to ensure it remains appropriate at all times and capable of flexing to meet the needs of the child, their

family and network - timescales for this must be included in the original plan and led by a key professional;
- identification of a lead professional in each plan to ensure accountability and so ensure effective communication and problem solving;
- include family members appropriately as part of every plan.

Consideration Three
Plymouth Safeguarding Children Board

Training and Awareness
Plymouth Safeguarding Children Board should review the training available for staff on working with children and families with complex needs. Training should include a general awareness raising for all staff, and targeted training for those professionals working directly with children and families with complex additional needs, including FASD.

Plymouth Safeguarding Children Board should raise awareness of the regional Forensic CAMHS service across the partnership.

Review and Audit
Plymouth Safeguarding Children Board should review the progress it has made in implementing the recommendations of the Child Q report published in 2015. As noted in this review, a number of similar issues have emerged and to avoid parallel recommendations, this review strongly endorses the earlier recommendations in relation to Strategy Meetings and the development of services the young people who display sexually harmful behaviour.

Plymouth Safeguarding Children's Board should audit its multi-agency professional awareness, confidence, competence and understanding of sexually harmful behaviour.

Consideration Four
All agencies.

The language used in describing harmful sexual behaviours and sexual offences is unlikely to be fully understood by the family. Professionals should use clear language when describing behaviour and offences and the risk associated so that this can be fully understood.

Multi-agency risk planning, assessment, intervention and behaviour management must take account of, and be influenced by, the child's or young persons' characteristics e.g. demonstrating more impulsive and opportunistic behaviours, being less specific in their choice of victim, or lacking empathy or remorse.