A local child safeguarding practice review (LCSPR) commissioned under

The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

David and Daniel

'UN21'

The Overview Report

February 2023

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1 Executive summary

1. The review is about how professionals responded to harmful sexual behaviour between two siblings; 11-year-old David and 14-year-old Daniel. They were in a long-term foster care placement with three other siblings (who are not the subjects of this review).

2. The fourteen organisations involved from the 1st of February 2020 until the 8th of December 2020 are listed in the appendix to this report. All of the siblings are subject to a care order. Their father died in 2012. Their mother has limited contact with the children and is not involved in their day-to-day care. The parents and the children are white British and English speaking as are the foster carers where the children were placed.

3. The use of acronyms and other devices is kept to a minimum. Professionals are referred to by their job titles.

4. The review was almost complete and this draft report was written by late 2021 when the police opened an investigation concerning another child who had been in the same foster placement with David and Daniel. The police investigation was completed in late summer 2022 with no criminal proceedings. None of the children was still placed with the foster carers. The review panel was reconvened in October 2022 to be informed about the circumstances of the police investigation and its outcome and agreed there were no additional issues for the review to consider before finalising the report. Some changes had occurred since the report was originally written. For example, some of the original people on the panel had moved on to other roles. Additionally, the separate clinical commissioning groups (CCGs) were replaced in July 2022 by a single integrated care board (ICB). Although the report records the individual Bassetlaw, Nottingham and Nottinghamshire CCGs as participating in the review, the recommendations and learning are carried forward into the Nottingham and Nottinghamshire ICB[1]. Despite the review being delayed by several months, all of the agencies had been working on the draft recommendations that were agreed upon in late 2021 and changes were being achieved by organisations by late 2022. For example, since November 2021 the LAC service improvement forum (SIF) has introduced a timeline pathway for the initial and review health assessment (IHAs and RHAs); the Children's Commissioning Hub have reviewed the service specification of the child in care (CIC) nursing service and looked widely at various models with a proposed new model under consultation but not yet in place; the wider review of the child looked after's journey from IHA through to leaving care is taking place. Policy and practice guidance about the use of any measures of control,

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[1] The ICB incorporates the CCGs into one organisation covering Bassetlaw, Nottingham and Nottinghamshire.

monitoring or restraint of children living in family-based as well as residential care has been updated. A more detailed account of progress against the recommendations agreed upon for the review will be kept in a separate action plan following publication.

5. David and Daniel, along with their siblings, moved from the carers who were looking after them at the end of 2020. David and Daniel are currently being cared for in different foster placements that are well-established and stable where both boys continue to have therapeutic care to help meet their individual needs. The carers who looked after David and Daniel at the time of the events examined by the review are no longer approved foster carers.

6. Sexual behaviour between siblings is not uncommon. It can be part of normalised behaviour that can be dealt with and corrected by sensitive parenting that establishes appropriate boundaries. It is behaviour that can become more problematic and abusive if unchecked and where there may be other underlying factors such as early exposure to sexual and other abuse, and severe neglect and can be further complicated by learning difficulties; these feature in the brothers' shared history.

7. The local authority and partners have invested effort and resources into improving the response to sexual abuse and the care of children who are looked after. Specialist practitioners are co-located with social workers, a multi-disciplinary panel provides advice and support and there are procedures and links to professional resources designed to help with a complex area of professional practice. Not enough use was made of this expertise or of the education and health professionals some of whom had a good understanding of the individual and specific needs of the children. The reports of sexual behaviour were recorded as new and isolated behaviour rather than being part of a longer-term history; this probably misled and misdirected discussion about risk such as in strategy meetings. Not enough attention was given to the earlier and adverse history of the brothers as context.

8. Significant factors in this particular case included foster carers who were confident in being delegated responsibility to liaise with the people from different services; a recognition that the children had experienced very adverse early childhoods and should remain together; and the undoubted complication of the national lockdown in response to Covid that disrupted working arrangements. This removed opportunity for informal consultation between co-located professionals in daily contact with each other as well as professionals having to adapt to new and remote working arrangements. Although the children could have attended school this did not happen partly because of the concerns on the part of the foster carers about Covid-19 infection and transmission.

9. Another factor was the reliance of some people outside of children's social care to accept at face value the early assertion that the sexual behaviour was not abusive. With hindsight, there should have been more challenge as well as greater consultation at the outset with health and education colleagues who were not involved in important discussions to clarify what behaviour was causing concerns, to develop an understanding about it and to agree on a more coordinated response.

10. Health arrangements for children in care have included the introduction of a voice of the child-in-care (CIC) practitioner intended to enhance opportunities to talk with children in care. The foster carers had opted out of this arrangement before lockdown although there was contact with other health and other professionals about Daniel and David such as anger management and night wandering although was not discussed as part of a wider consideration of history.

11. Organisational pathways in health are complicated for people working outside the health community and contributed to misdirection and breakdown in communication including invitations to reviews. The county’s LAC health service specification is focused on meeting statutory requirements for health assessment and reviews in line with regulatory standards. In other parts of the region, a broader service ensures key health professionals are identified for children to facilitate effective communication with partners such as social workers as well as assisting with fast-tracking referrals into relevant services when necessary. This is the voice of the child pathway. This is provided by the Healthy Family Team (the Healthy Family Team are provided by the same organisation as the CIC nursing team (NHFT). At the time of the incident, the voice of the child pathway was a new service and therefore communication pathways were not fully embedded which is likely to have contributed to the misdirection of invitations to review meetings.

12. Current commissioning in Nottinghamshire does not have a single lead professional overseeing important aspects of a child’s health and development. Children who are looked after are known to have more complex behavioural, emotional, psychological and developmental needs compared to their peers. Children who have more complex needs and behaviour will need more expert and therapeutic support; different forms of therapy need to be matched with the circumstances of the child and cannot be one-size-fits-all. Promoting their resilience, ensuring access to timely support and caring for the most vulnerable children and young people such as David and Daniel require well-established day-to-day partnership working.

13. The use of highly restrictive measures as an attempt to prevent sexual behaviour between the siblings was motivated by a desire to keep children safe. It was done without enough consideration of law, best

practice or seeking appropriate authority. It did not address the underlying factors for the behaviour.

14. People like the independent reviewing officer (IRO) have important legal responsibilities in making sure care planning is meeting the needs of children. They were not kept appropriately informed about significant information quickly enough. The IRO also has a role in providing advice and if necessary, escalating action if professional responses need to be changed.

2 Focussed chronology before December 2020

15. The care orders made in 2013 were because of severe neglect. The two eldest children (not David or Daniel) had lived for a while with their maternal grandfather under a residence order. The parents had a history of alcohol and domestic abuse and poor mental health. Home conditions had been extremely poor and unsafe, with the children often relying on neighbours to feed them. They had poor school attendance, suffered injuries when left unsupervised for long periods, and suffered enduring developmental delays.

16. David has an Education, Health and Care (EHC) plan. He has ADHD and significant learning difficulties, taking medication for his ADHD. He has dyspraxia, hypermobility and microcephaly and was assessed but not diagnosed with an autistic spectrum disorder. David has a history of poor sleep and night wandering. He attended the same specialist school as Daniel from September 2020.

17. Daniel has a learning disability and has been assessed for autistic spectrum disorder although the diagnostic criteria were not met. There are concerns that both Daniel and David were exposed to alcohol in utero although this was not confirmed. Their mother denies using alcohol during the pregnancy.

18. In February 2020 David's teacher intercepted a note from David to a younger pupil professing 'love' for the other child. The note was shared with his social worker and work was jointly planned with David around relationships.

19. David's EHCP was updated in late February 2020 with information that he had become violent and aggressive and was often self-harming. There was a reference to inappropriate behaviour with siblings but no further detail.

20. In late March 2020, the foster carer alerted the student social worker to a note that David had shared that he had been given by Daniel. There were kisses on the note and the word "sexy". Both children were spoken to and Daniel said that he and David sometimes kiss. Daniel said that

David came into his room, they kissed, and it would not stop and they have sex.

21. The social worker agreed on arrangements with the foster carers to increase the supervision of the children in the home. David's bedroom was changed to be closer to the foster carers and monitors were installed to alert if bedroom doors were opened and closed. The carers were expected to do work on safe touch and the NSPCC 'pant rule'[2]. There could and probably should have been a consultation with the independent reviewing officer (IRO) about significant developments in the placement and in particular the use of enhanced monitoring.

22. A strategy discussion in early April 2020 limited to CSC and police agreed on a single agency Section 47 investigation with no role for police. No health professional was included in the strategy discussion or subsequent follow-up. There is a limited written record about specific information that was discussed or about action agreed upon. A month later a multi-agency meeting agreed that further therapeutic work was needed with the two children. A referral to the dyadic developmental practitioner[3] was not initially progressed as it needed to be face-to-face and Covid -19 restrictions prevented this.

23. During a home visit by a duty social worker in late April 2020, over a month after the March 2020 disclosure to the foster carer, David disclosed that he used to go into Daniel's bedroom quite a lot the previous year (2019), but it had stopped, Daniel had tried to kiss him on the cheek and lips. David disclosed Daniel had touched him.

24. David said that he did not like it and that it did not feel right, so when Daniel gave him the note, he told his foster carer. He said he felt safe now it had stopped as he did not want to do it anymore. The social worker concluded after speaking with both boys which had included seeking their respective views and feelings that although the behaviour was inappropriate it was judged to be experimental due to the level of understanding and that work needed to be focused on more appropriate relationships. The allocated social worker was shielding because of Covid but the duty social worker who spoke to the boys had consulted the allocated social worker before and after the visit. They had also spoken to the school. There is little recorded information about what the social worker knew about the boys' understanding and that this had not

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[2] https://www.nspcc.org.uk/globalassets/documents/advice-and-info/underwear-rule-children-guide-english.pdf/?

[3] DDP can help children who have been hurt and/or neglected within their families in their early years and are struggling with better healthy parenting and to make emotional connection. Children can be traumatized by these experiences and find it difficult to feel safe and secure within their new families. This is sometimes called developmental trauma.

been consensual behaviour. There were conversations with the therapeutic team but no wider multi-agency discussion.

25. All of the siblings had their annual LAC health review in early May 2020. ADHD was a focus of David's health review and his anger was described by the foster carer as a 'major issue'. He was house-wandering at night and urinating in his bedroom. There was no CIC nursing team representation at the LAC review in May 2020 because the invitation had been sent to the wrong team and had not been forwarded. They did not have copies of the LAC[4] review minutes or documentation. The GP was invited but sent apologies. The CIC nurse did not have information regarding the alleged sexualised behaviour and assaults. The social worker's report to the LAC review in May 2020 noted the "safeguarding concerns about the sexualised behaviour" which was picked up by Daniel's school who would also have David on the roll from September 2020.

26. In mid-May 2020, a referral for therapeutic work with all of the siblings was allocated to a fostering family worker. The referral described that neither Daniel nor David had been forced in any way. The summary did not fully reflect the information originally recorded by the duty social worker's visit and one-to-one discussion with David the previous month. Delays in work starting were attributed to the foster carers' commitments and school holidays.

27. In late May 2020, the school was made aware of concerns regarding the brothers' sexualised behaviour by the social worker who reported that it was normalised exploratory behaviour that had gone too far. The school agreed to support Daniel on his return to school with 1-1 sessions delivered by their mental/sexual health lead professional.

28. In early September 2020, the foster carer informed CSC of a further incident over the bank holiday weekend when Daniel was in David's bedroom. This led to a visit the following day when David disclosed to the social worker that Daniel had come into his bedroom, taken his clothes off and laid on top of him. Daniel had tried to kiss him and touch him. A strategy discussion was held with police and a single agency Section 47 investigation was agreed upon. No other service was involved in the strategy discussion.

29. A meeting between CSC and the school in early September 2020 discussed the safety of Daniel remaining in the same placement with his siblings and arrangements at school. It was agreed that a referral to the HSB panel[5] would be made although this did not start until early October

[4] Looked after child review

[5] Harmful sexual behaviour panel.

2020. The social worker had completed the Brook risk assessment[6] at red before being absent from work due to illness. This coincided with the absence of other lead professionals including the team manager and the fostering team manager. The fostering duty system provided CSC cover until the end of October 2020.

30. In mid-September 2020 the foster carer informed EDT that a friend had told them that David and the friend's 8-year-old son had been holding each other in their 'secret club' during a sleepover[7].

31. A LAC review was held the following week but did not include the CIC[8] nursing team who did not receive an invite. The independent reviewing officer (IRO) was concerned about the incidents of sexual behaviour that had occurred in a short space of time and recommended a further review in six weeks. Daniel remained in the placement. A harmful sexual behaviour (HSB) assessment was begun and a referral to the Harmful Behaviour Panel was made with a booking agreed for 19th January 2021, three months later. By this time David had started at Daniel's school and the LAC meeting and the school agreed to keep the two brothers apart and to make sure they were sitting separately on the bus.

32. In early December 2020, David disclosed serious sexual assaults on several occasions by Daniel. The disclosure was made to a student social worker, during a home visit arranged to complete self-protection work, who was working alongside the children's social worker and the practice consultant undertaking a harmful sexual behaviour (HSB) assessment.

33. David's disclosure triggered the rapid review that resulted in this review being commissioned.

3 Application of relevant research, policy and other reviews

34. Sexually harmful behaviour between siblings is likely to be encountered by child protection professionals. Sexual abuse involving child siblings is thought to be the most common form of intra-familial child sexual abuse (IFCSA); perhaps up to three times more common than child sexual abuse by a parent[9].

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[6] https://www.brook.org.uk/training/wider-professional-training/sexual-behaviours-traffic-light-tool/

[7] This was referred to the LADO (local authority designated officer).
[8] Child in care team
[9] Krienert, J. and Walsh, J. (2011) Sibling sexual abuse: An empirical analysis of offender, victim, and event characteristics in National Incident-Based Reporting System (NIBRS) data, 2000–2007. Journal of Child Sexual Abuse, 20(4):353–372. https://doi.org/10.1080/10538712.2011.588190 and cited in

35. Sibling relationships are complex and especially so for children who have had abusive or adverse parenting. Severe neglect in early childhood and/or suffering trauma and disrupted attachment can create conditions that lead to developmentally unhealthy sibling relationships. Understanding the nature of the relationship between different siblings should be an essential part of assessment and care planning when for example siblings are being placed.

36. Children such as David and Daniel who suffer severe neglect in their early childhood will present with additional levels of developmental and cognitive deficits requiring effective working between education, health and social work professionals.

37. Defining when and what sexual behaviour between children is harmful requires an understanding of what constitutes developmentally appropriate and healthy sexual behaviour in childhood along with an awareness of informed consent, power imbalances and exploitation. Defining what is normative or less concerning sexual behaviour needs to take into account the social-emotional and cognitive development as well as the age of individual children. Sexual behaviour that falls outside what is agreed to be a normative range might cause physical and/or emotional harm and can range from inappropriate behaviours to something more serious such as penetrative sexual assault.

38. Distinguishing between different forms of sibling sexual behaviour is an essential part of providing effective care that promotes healthy relationships and protects children from harm and abuse. Understanding the nature and quality of the relationship between siblings is important when assessing the nature of sibling sexual behaviour.

39. It needs professionals to be careful and precise about the language they use to describe behaviours that can encompass normative sexual interactions between siblings through to sibling sexual abuse that causes sexual, physical and emotional harm including behaviour that involves coercion or violence. National studies and research identify a continuum across three types of sibling sexual behaviour;

    a) Normative sexual interactions between siblings; behaviour between young siblings that exists within expected developmental norms;
    b) Inappropriate or problematic sexual behaviour involving siblings; behaviour between siblings that fall outside

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https://www.csacentre.org.uk/csa-centre-prodv2/assets/File/Sibling%20sexual%20abuse%20report%20-%20for%20publication.pdf.

developmental norms and which may cause developmental harm to the children involved;

c) Sibling sexual abuse; is behaviour that causes sexual, physical and emotional harm, including sexually abusive behaviour which involves violence[10].

40. Sibling sexual behaviour that is outside developmental norms might emerge from sexual games or play that goes unchecked; a lack of appropriate supervision and boundary setting. For some children it is a way of dealing with stresses in their lives; siblings who are looking for nurture and support or have learnt to seek it in the absence of good and healthy parenting experiences and the behaviour becomes sexualised within the context of other abuse or stress, current or historical. This resonates with the known history of the siblings.

41. There is no single cause for harmful sexual behaviour in childhood but several adverse life experiences are identified as common in children with such behaviours. Common risk factors include prior sexual and physical abuse, neglect, family violence and trauma. This resonates with the history of the children. According to Hackett 'There are likely several developmental pathways into harmful sexual behaviour, combining biological, social and environmental risk factors[11].

42. Sibling sexual abuse may involve a wide range of behaviours over a long time; it can include sexual touching, penetrative sex acts and non-contact such as voyeurism. It is abuse that is even less likely to be disclosed than other forms of sexual abuse where disclosures are known to be under-reporting the incidence of abuse. The impact of the abuse may not be apparent until adulthood and differs from child to child.

43. Professionals who become aware of sibling sexual behaviour need to be careful of making assumptions by exploring the likely impact on each child by considering the nature, duration and context of relationships, the meaning of the behaviour to the siblings involved and the response of the carer and other protective and vulnerability factors. In this case, the history of abuse before becoming looked after, the respective learning difficulties and how the children communicated were all relevant factors needing to be taken into account with the help of other people who knew the children well and had relevant experience and expertise. It was also

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[10] https://www.csacentre.org.uk/csa-centre-prodv2/assets/File/Sibling%20sexual%20abuse%20report%20-%20for%20publication.pdf. P 5 and also in Hackett referenced in footnote 11

[11] Hackett. S, (2020) Sexual violence and harmful sexual behaviour displayed by children: Nature, causes, consequences and responses, Report to Steering Committee for the rights of the child Available at https://rm.coe.int/cdenf-gt-vae-2020-09-concept-paper-harmful-xexual-behaviour/1680a080a2 Accessed 07/05/2021

occurring during the Covid-19 lockdown that caused unprecedented disruption.

44. Best assessment practice requires that the emotional, physical and sexual safety of all the children in a family is secure. This may require detailed safety planning which in this case needed the involvement of the foster carers, school and health professionals. It should include consideration as to whether the child who is harming another should be placed somewhere else at least until an assessment has been completed. Good assessment is informed and guided by appropriate frameworks and tools some of which are described in the CAS study as well as in NICE guidance (para 1.6.2)[12].

45. In terms of intervention, family-based rather than individually focussed approaches are thought more likely to be effectively supported by a coordinated multi-agency approach involving carers as partners in the decision-making. Reflective supervision and support for those most closely involved are likely to be required. The harmful sexual behaviour (HSB) framework[13] provides an evidence-informed tool for developing coordinated multi-agency responses to children and young people's HSB to help local areas develop and continue to improve responses to HSB.

4 Single agency learning and conclusions

46. The placement of the six siblings in the same placement with experienced foster carers was a significant achievement by social workers at the time of the Family Court proceedings. It is a generally accepted axiom of professional practice that children should as far as possible grow up with a strong sense of their own and their sibling's identities. The placement appeared to be stable and well established and the foster carers were confident working with health and school staff as well as social workers.

47. There had been earlier reports to social workers of the foster carers dealing with some inappropriate behaviour such as unwanted cuddles and inappropriate comments by Daniel that he wanted to see a girl naked; the behaviour was seen as being inappropriate and was not discussed with other professionals at the time. It meant that health

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[12] National Institute for Health and Care Excellence (2016) Harmful Sexual Behaviour among Children and Young People [NICE Guideline NG55]. London: NICE. Available at: www.nice.org.uk/guidance/ng55

[13] Hackett, S, Branigan, P and Holmes, D (2019). Harmful sexual behaviour framework: an evidence-informed operational framework for children and young people displaying harmful sexual behaviours, second edition, London, NSPCC. Available at https://learning.nspcc.org.uk/research-resources/2019/harmful-sexual-behaviour-framework/

professionals were not made aware of potentially significant information in processes such as the routine health reviews of children looked after by the local authority.

48. There was a good level of general understanding across the different professional groups that Daniel and David with their siblings had been neglected when in the care of their parents and extended family. There was less detailed information about the extent of the abuse and their exposure to sexual harm. Some of the family members who cared for the children had sexual offences recorded against them. The research evidence summarised in the previous section highlights the importance of developing a good understanding of how such adverse early childhoods have affected individual children and professionals being curious and well-informed about understanding how for example individual children relate to their siblings.

49. When the school reported the information about the intercepted note in February 2020 it was processed in isolation from the earlier information reported by the foster carers. It also coincided with the emergence of the national Covid-19 pandemic which had a profound impact on professionals being able to see the children and the foster carers face-to-face or meeting with each other. All of this influenced how individual people and agencies were able to work with each other and the children. As children who were looked after by the local authority, Daniel and David were eligible to attend school although this did not happen; the foster carers were concerned about contracting Covid-19 due to heightened health concerns and felt safer having the children at their home. This limited the opportunities for the school to see the children.

50. Of all of the services, the school had the clearest understanding of Daniel and David's respective cognitive and learning abilities. For example, it was the school that was able to describe how Daniel's understanding of what was socially appropriate behaviour was neither age appropriate nor in line with his abilities and how this had probably been affected by his early childhood abuse and adversity. The school described Daniel's tendency to react in terms of shame and blame when his behaviour was scrutinised rather than having an understanding and appropriate capacity for self-control. This level of understanding can help foster carers or other professionals working with children in Daniel and David's circumstances.

51. The assessment and strategies to address sexual behaviour could have been enhanced with a better inclusion of the insight that the teaching staff had. Daniel typically reacted by agreeing to what he was told at a given moment without necessarily processing what he was being told. It is an example of where the importance of professionals who have good knowledge about a child is essential to developing an understanding of

why a child is behaving in a particular manner and can assist in developing behaviour and safety strategies.

52. Matters were further complicated because of Covid. For example, the allocated social worker needed to shield and therefore duty social workers tried to maintain the involvement of the service with the children but could not be in a position to fully understand history or know the children in the same level of detail as some other professionals. Discussions that take place as a one-off rather than as part of established relationships can influence how people understand and potentially underestimate the significance of incidents or behaviour.

53. The review highlights the importance of ensuring that people who know children well are involved in critical discussions and need to be treated as trusted and equal partners in processing information and analysis. The school accepted explanations from different social workers that Daniel's behaviour was not abusive. Combined with the foster carers' concerns about Covid-19 and keeping the children at home, the school were not in a position to participate and influence how information was being understood and to help develop strategies.

54. The local authority has commendably invested in developing the capacity of its social work services to respond to sexually harmful behaviour. This includes co-locating specialist practitioners with social workers to encourage timely consultation, advice and support in working with children who are displaying harmful sexual behaviour. There was no consultation with these specialist practitioners. The remote working required under Covid-19 was a significant factor; professionals lost the co-located benefits of working nearby to each other. Another influential factor was different social workers being involved at different times sometimes to cover a statutory visit or to respond to a specific report of concerns such as that occurred with a duty social worker.

55. There were other factors. An understandable mindset that wanted to support a placement that was seen to be working in the interest of keeping a larger sibling group together. Being empathetic to a sibling group who had suffered significant abuse in their early childhoods. Possibly seeing consultation with an HSB specialist as only necessary after arriving at a diagnosis of harmful sexual behaviour rather than consulting at an earlier stage about how assessment and enquiries needed to be planned and taken forward. The delays in using the specialist practitioner or making a referral to the HSB panel persisted until late 2020 despite several suggestions and recommendations from professionals and the IRO.

56. The local authority has also developed therapeutic support services for children placed with foster carers. This has included training to foster carers and included the carers looking after David and Daniel.

Therapeutic support services are focused on helping children who have been traumatised rather than being a specialist resource for children who are displaying sexually harmful behaviour (which can be a symptom of a traumatised childhood). It is not a behaviour change framework. A referral was made to this service. Health colleagues were unaware of the referral until May 2020 when the foster carer told the Healthy Family Team (part of the Child in Care health provision) that the referral was to help with “anger management issues”.

57. The Looked After Child Review Health Assessment in May 2020 included telephone contact with the foster carers and children. As part of that contact, the foster carer described social work assessments of ‘concerning behaviours’ being exhibited by Daniel towards “another young person”. The assessments were described as ‘ongoing’. This information was subsequently followed up by the CIC nurse with the social worker who confirmed the assessment was due to “an incident of a sexual nature” between Daniel and David. The social worker confirmed that ‘safeguarding measures were in place’. There was no further detail about what the behaviour was or the safeguarding measures that had been put in place. There was no contact with the CIC nursing team over and above the routine contacts. The CIC nurse had discussed puberty and sexual health with both boys during previous review health assessments and did not revisit the issue due to the assessment being completed through more impersonal telephone contact rather than face-to-face.

58. The Nottinghamshire Healthcare NHS Foundation Trust introduced the voice of the child in care practitioner as an enhanced contact by the HFT; this is an additional contract over the universal service specification for other child peers. The purpose is to review and monitor progress with health recommendations outlined in the review health assessment and is intended to give the young person the opportunity to talk with a health professional between the annual assessments. The foster carers felt they did not need this enhanced arrangement.

59. During the LAC health assessments, the foster carer disclosed concerns about David’s behaviours; this included difficulties in managing his temper, house wandering, and ‘inappropriate toilet issues’. The health care practitioner processed the information as being symptomatic of David’s learning difficulties rather than as an indication of abusive behaviour or the impact of trauma. As with other professionals, the foster carer was regarded as experienced and coping effectively with the children therefore there was no follow-up with other services and the information did not feature in the statutory LAC reviews or various referrals to specialist services.

60. In September 2020 a nurse in NUH who did not work in a paediatric service had a telephone discussion with the foster carer about a clinic

referral from the community paediatric services. During that discussion, the foster care talked about Daniel presenting a risk to David; the nurse appears to have accepted this was an issue that was already being dealt with. The conversation was not reported to Daniel's consultant or the safeguarding team at the hospital on the basis that it was believed the information was already known by the relevant professionals and that action to protect the children would already be in hand. Although it was not an unreasonable assumption that professionals would be acting to protect children it assumed that other professionals had the information and removed an important part of multi-agency work where professionals analyse and make judgments about what individual jigsaw pieces of information might represent.

61. The two strategy meetings that discussed Daniel's behaviour were limited to the police and children's social care (CSC). The first meeting had no information about the behaviours that had been reported from late 2014 and had no information to suggest that there had been previous concerns. Although the school had originally reported the behaviour by Daniel to another pupil they were not asked to participate in the discussion. None of the health professionals was told of the information or invited to participate in the strategy meeting and remained uninformed until more explicit evidence of sexual abuse was disclosed later in 2020. Both strategy meetings decided that the police should not open a criminal investigation. It is possible that if the police had been aware that the sexual behaviour was not an isolated incident, they may have wanted to be a party to a joint S47 enquiry although not necessarily with a view to a criminal prosecution involving such young vulnerable children. This would have allowed a joint interviewing strategy to be agreed upon between the two services. The police asked that CSC consider making a referral to the children's independent sexual violence advisor service at the first strategy meeting and suggested a referral to the HSB panel at the second meeting. CSC and police both recorded that safety plans were in place for the children.

62. Daniel, David and their other siblings were all registered with the same GP from the time they had been placed with the foster carers. The only information the GP practice had was a reference to "inappropriate sexual behaviour" in a letter from the community paediatrician in September 2020.

63. The community paediatric service saw both boys and was consulted about Daniel's outbursts of anger and night wandering. The foster carer was the main point of contact with the community paediatric service rather than social workers.

64. The local authority has written procedures about what should be done in response to information about sibling sexual behaviour. The procedures

also refer to the specialist AIM assessment tool[14] recommended in NICE guidance and the CAS study. The harmful sexual behaviour assessment was completed when disclosures were made about Daniel sexually assaulting David in late 2020.

65. The foster carers increasingly used electronic monitoring and locked doors to prevent Daniel's night-time visits to David's bedroom. These restrictions were not discussed at statutory reviews or discussed with legal professionals but were done with the consent of social workers.

66. Restrictions on children's movement or the use of intrusive monitoring need to take proper account of the rights of all children who might be affected by any measures and to ensure that it complies with relevant legislation and guidance. It also has to distinguish between measures that address issues of immediate risk to a child and longer-term strategies.

67. The use of measures that restrict the liberty of children is subject to UK law and international conventions about human rights. Section 25 of the Children Act allows children only to be held in secure accommodation that is licensed and regulated for that purpose. The use of electronic devices to monitor or restrict the movement of children inside their foster carers' homes has to take into account what is legal. The use of any monitoring and surveillance should only be for the protection of children and needs to show that it meets the needs of all children who will be subject to the measures. The effect on all of the children needs to be considered and kept under review and the consent of the children subject to age and understanding be sought. The arrangements need to be included in care plans and be part of the statutory oversight by the IRO. The significant issues of human rights along with complex laws and regulations require clear and informed guidance that involves an appropriate legal professional.

5 Partnership learning and conclusions

68. Sibling sexual abuse, the most common form of intra-familial child sexual abuse (IFCSA), is highly likely to be encountered by professionals working with children. As with other forms of CSA, it can be hard for people to recognise and by definition, it is a hidden and often secret form of abuse.

69. There are good reasons for professionals to be wary of mislabelling behaviour. Compassionate professionals working with children who have suffered abuse will expect to see evidence of their harm and trauma

[14] http://www.newsite.aimproject.org.uk/portfolio-item/model-and-guidance/

in how the child behaves and will not want to exacerbate the child's difficulties with insensitive or inappropriate responses. Matters are further complicated when children may be dealing with additional challenges such as a learning difficulty or disability.

70. In this case, Daniel's behaviour was judged to be inappropriate rather than abusive. Beginning with a more reflective approach that asked what the behaviour represented and seeking the help of relevant people to help develop an understanding and to provide some constructive challenge would have been helpful. It is acknowledged that in the spring and early summer of 2020, everybody was trying to find new ways of working within the Covid restrictions that had a profound impact on all services and the important inter-professional communication that for example comes from physical co-location. The behaviour management strategies intended to keep the children safe became ever more restrictive coinciding as they did with a national lockdown that prevented professionals from seeing the children.

71. Severe neglect as experienced by David and Daniel, the potential disruption in their attachment and the possible trauma given the chaotic conditions the children were removed from created the latent conditions in which developmentally unhealthy relationships could take hold and at least deserved discussion and consideration alongside other information. The importance of a reflective mindset informed by relevant research evidence and the input of multi-disciplinary expertise is an important point for partnership learning and applies to placement planning, strategy meetings and statutory review processes including health reviews.

72. The importance of describing behaviour to promote a clear understanding of what is happening to children is another lesson for partnership practice. Professionals should have the confidence to challenge each other if they feel language is imprecise or euphemistic or if there is not enough care and discipline in providing evidence to support expressed judgments. It is not good enough to rely on a professional simply asserting a judgement about what behaviour represents or that safeguarding is in place. Children are kept safe by curious and persistent professionals sharing responsibility for achieving good outcomes for children.

73. Another area where language is important is when professionals try to establish the level of understanding of individual children. Simply ascribing the term learning difficulties is not good enough. The school were the only professional who was able to provide some insight into how Daniel and David understood the world and their behaviour and interaction with other people but were not a party to crucial discussions. The schools have acknowledged that they need to be more assertive in how they interact with people such as social workers and foster carers

rather than relying on them necessarily having the requisite understanding.

74. The statutory processes such as strategy meetings, LAC reviews and health reviews could have been more effective in helping understand and respond to the behaviour. The CIC nursing team were not invited to the statutory LAC review in May 2020 and had very short notice of the LAC review in September 2020. This arose from an error in the routing of information between CSC and the health Trust arising from the reconfiguration of arrangements in the health team. This has been dealt with and therefore no recommendations are made by the Trust or in this report. Since the review was completed in late 2021 the CIC health arrangements have become more embedded.

75. Some recommended actions from LAC reviews were not carried through and others were subject to significant delay. Arguably there were grounds to have escalated concerns at an earlier stage about the pace and appropriateness of response although it is acknowledged that Covid represented an unusual and significant disruption to working arrangements. This included the supervision and support arrangements for the foster carers who relied too much on developing their management strategies such as restricting and monitoring children's movements and keeping children away from school or scheduled appointments because of health concerns.

76. Effective help to children at risk from harmful sexual behaviour relies on confident well-informed sharing of information that describes clearly the behaviour giving rise to concerns, clear pathways that ensure relevant people are consulted, is focussed on the child's level of understanding and that agreed action is followed through.

77. The importance of children having sufficient opportunity to disclose concerns and guard against interpreting behaviour and inferring meaning where descriptions of behaviour were euphemistic and imprecise on occasion. With notable exceptions, there is insufficient recorded evidence about how either boy felt and their understanding was explored. The duty social worker who spoke to both boys and did record in better detail how they felt as well as their wishes did not have detailed knowledge about the boys' circumstances. The duty social worker had spoken with the boys' allocated social worker before and after seeing them. None of the education or health professionals was invited into discussions about behaviour and they were given assurances that the children were being safeguarded.

78. When concerns such as potentially harmful sexual behaviour are raised about a child who is looked after the information is not routed through the multi-agency safeguarding hub arrangements but is sent to the child's social worker. Some panel members queried why the allocated

social workers when they receive new safeguarding concerns do not always respond as robustly as the MASH about information sharing with partners and timely s47 strategy meetings including key agencies like health and education.

79. The learning from the review is summarised:

a) **Professionals including social workers in looked-after and fostering teams working with children need to feel confident about how to respond to child sexual behaviour:** sexual behaviour between children is not uncommon and covers a spectrum; sexual abuse between siblings is thought to be the most common form of intrafamilial child sexual abuse**;** different professionals have a role in developing a good understanding of what a specific child's behaviour represents; teachers often know children better than other professionals from their day-to-day contact and can also provide insight into how a child understands what is happening; health professionals may know children well and will have a good understanding about child development and psycho-sexual behaviour; social workers and police have clear roles and responsibilities in ensuring appropriate enquiries and investigations are properly planned and carried forward;

b) **Use of expertise, toolkits and best practice guidance:** the East Midlands Children and Young People's Sexual Assault Service (EMCYPSAS)[15] is available to children and young people under the age of 18 who have experienced rape or sexual assault; by using this service (professionals can also make referrals) children and young people receive immediate medical assessment and care with follow up care and therapeutic support; the local authority has invested in developing expertise on harmful sexual behaviour; they have a role in being consulted and providing advice at an early stage; relevant professionals being aware of and confident to use recommended professional frameworks and toolkits as described in the national CSA study and NICE guidance;

c) **Euphemistic or imprecise language:** understanding whether the behaviour is normative or something more concerning begins with as clear as a possible description of what has happened including the child's account; some professionals were highly reliant on summaries being given by other professionals who had already made a judgement about the behaviour;

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[15] https://www.emcypsas.co.uk/

d) **The influence of history and why it has to be understood:** the information about sexual behaviour in 2020 was erroneously treated as new and emerging rather than part of something more long-term; early neglect, trauma, exposure to sexual and other abuse, poor attachment, the development of inappropriate sibling relationships seeking nurture and support are some factors that create latent conditions for harmful sexual behaviour;
e) **Not all siblings are best served by living in their family group:** larger sibling groups by definition are more complex and represent very significant challenges for people striving to find secure long-term placements; any risk assessment and safety strategy has to take into account the needs of all the children;
f) **Organisational pathways and effective cross-agency working:** at the time of the incidents the voice of the child pathway was a new service arrangement and therefore communication pathways were not fully embedded. The commissioning of the statutory CIC services is through the ICB whereas the local authority public health service is responsible for commissioning 0-19 services; in other parts of the region, a broader LAC service is provided where key health professionals enable effective communication, work with partners to establish fast track referrals for LAC. Some of the communication difficulties including routine notification of LAC reviews arose through multi-layered pathways. For children with complex histories there are particular challenges in achieving effective team around-the-child working arrangements which bring education, various health as well as social work professionals together;
g) **Clarity about the role of foster carers:** the emergence of Covid exacerbated the degree of influence the foster carers had in communication with different professionals especially when there were some difficulties with key staff not being available for some time.
h) **Role of the independent reviewing officer (IRO) and professional curiosity:** statutory guidance states the IRO's primary focus is to quality assure the care planning and review process for each child and to ensure his/her current wishes and feelings are given full consideration; to be successful the role must be valued by senior managers and operate within a supportive service culture and environment[16]; the IRO has important statutory

[16] IRO Handbook statutory guidance Para 1.21 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/337568/iro_statutory_guidance_iros_and_las_march_2010_tagged.pdf

responsibilities for the oversight of care planning and arrangements for children who are looked after; they should be expected to have enhanced levels of knowledge and understanding about legislation, child development and best professional practice to provide support and ensuring plans are meeting children's needs. David and Daniel were with the foster carers for several years and therefore the foster carers were powerful; they had delegated responsibility and a lot of influence as to the narrative around the children; the importance of social work professionals maintaining professional curiosity with foster carers and resisting making an assumption that experienced and well-regarded carers are managing the situation and responding appropriately all of the time.

6 Learning already implemented

80. Children's social care (CSC) has revised and updated procedures and practice guidance on the issue of permitted measures in family and residential placements to keep children safe. CSC is raising awareness and promoting the use of the HSB practice consultant leads with all social work teams including fostering and those working with looked after children. A rolling programme of training delivered by the HSB practice consultant leads is available to all social workers and managers throughout the year. Specialist child protection coordinators are also available for social work support and CAMHS are commissioned to offer consultancy for those working with children and young people with more complex needs. Improvements are being made to the collation of chronologies in the fostering and looked-after services.

81. The Independent Reviewing Officers (IROs) have had learning and development sessions specifically about this review but also in respect of safeguarding for looked after children. This has included safeguarding risks outside of the home but also professional curiosity and 'thinking the unthinkable' for children and young people in the care of the local authority. The IROs have visited social work teams with a presentation about their role and responsibilities. They also have been given the time to reflect on their roles and responsibilities and to consider how they reassure themselves that they are delivering these. The IRO dispute resolution process has been updated and has been shared across social work teams. The Independent Chair Service continues to develop its practice through assessment of data and audit and has extended its data collection to include escalations to partner agencies and will report on this annually to the Nottinghamshire Safeguarding Children Partnership.

82. The schools had provided the children with weekly one-to-one sessions with a dedicated member of staff to provide an opportunity to talk about any concerns they might have. The primary school is doing work on improving the quality of record-keeping. Additional guidance is being developed to clarify who is best placed to make educational decisions about children who are looked after and to make distinctions between a foster carer and a social worker for example. Schools are also to be provided with guidance and encouragement to constructively challenge decision-making when schools have concerns that it is not reflecting the best interest of children.

83. The community paediatric service is improving the acknowledgement and recording of the child's voice in consultations.

84. The CIC specialist nursing team aims to improve the effectiveness of communication with the social worker and looked after services. This includes improving administration arrangements. Improvements are also to be made to the internal management and processing of LAC documentation. The use of escalation procedures and updating of safeguarding training to promote the use of escalation processes.

85. The NUH has reminded staff about the importance of maintaining professional curiosity and asking relevant questions and the same level of curiosity and scrutiny needs to be applied to children who are looked after as to those who are not.

7 Action for the implementation of learning and development

86. A learning summary will be circulated.

    I. The Director of Children's Services should ensure that the policy and practice guidance about the use of any measures of control, monitoring or restraint of children living in family-based settings and residential care is being effectively implemented.
    II. The Director of Children's Services should ensure that social workers in looked after children's services receive the appropriate training in harmful sexual behaviour and that they access support from HSB specialist practitioners when appropriate. The effectiveness of this should be monitored through the department's Learning and Improvement Board.
    III. The Director of Children's Services should ensure that the Learning and Improvement Board give sufficient priority to the role of the IRO, to be assured that it is performing in line with policy expectations and making an impact on children's outcomes including effective and timely escalations responses including those escalations between agencies.

IV. The ICB and local authority public health service should jointly review current arrangements for the health care of children looked after in Nottinghamshire. The purpose of the review is to consider how a more holistic arrangement includes statutory health care reviews within a clearer health care pathway of liaison with social work services and overseeing health care assessment and planning.

V. The chairs of the LAC and care leavers board and the local safeguarding children partnership should provide clarity about the lines of accountability to promote and monitor safeguarding and health care for young people who are looked after.

VI. At the next meeting of the relevant partnership sub-group in January 2023, partners should develop a joint action plan to address the learning about responding to new child protection concerns for children who are looked after. Progress against this should be reported to the SAIG within six months (July 2023).

VII. The Harmful Sexual Behaviour Steering Group should consider whether further work is required as a result of this review. This might include considering the availability and type of therapeutic and other support to work with children presenting with sexually harmful behaviour. The Chair of the steering group is responsible for ensuring this work is undertaken.

8 Agencies who contributed information to the review.

The following agencies have provided information and have participated in the learning events conducted remotely for the serious case review:

a) Nottinghamshire Police; as part of the MASH received information about sexual behaviour between the two siblings; on the first two occasions strategy meeting decided that CSC would complete a single agency investigation; on the third occasion in December 2020 the police opened a criminal investigation that was ongoing when the review was commissioned;
b) Nottinghamshire County Council Children's Social Care; involved with the siblings over many years more recently providing ongoing supervision and support to a long-term foster care placement that included statutory reviews by an independent reviewing officer (IRO); as part of the MASH and statutory involvement through the Care Orders CSC had information about sexual behaviour and additional information from one of the schools; CSC undertook two single agency investigations before the joint investigation was opened with the police in December 2020;
c) Nottinghamshire County Council, Education, Learning and Skills about a specialist school attended by David and Daniel; a secondary Academy school attended by the older siblings; information from Daniel's primary school; as children looked after by the local authority both children had a statutory education, health and care plan (EHCP)

and as part of that process the educational psychology service (EPS) had direct contact with both boys which include assessments to inform the EHCP; the virtual school service had involvement with Daniel when he transferred from primary to secondary school which occurred before the scoped timeline for the review;

d) Bassetlaw, Nottingham and Nottinghamshire CCGs (replaced by the Nottingham and Nottinghamshire ICB from July 2022);
e) Nottinghamshire Healthcare NHS Trust (NHCT); both siblings are known to the 0-19 Healthy Family Service which includes the child in care specialist nursing service who had routine contact;
f) Nottingham University Hospitals NHS Trust (NUH); had contact with David through a clinical geneticist regarding concerns about learning difficulties and behaviour; there were concerns he had foetal alcohol syndrome (FAS)[17] but did not have typical features for a diagnosis; the service had more recent involvement following the opening of a safeguarding investigation to provide assessments; the community paediatrician had made a referral as well in respect of Daniel about the significant history of delayed learning and learning difficulties in the family history;
g) Sherwood Forest Hospital Trust (SFHT); the community paediatric service saw David about learning difficulties and potential concerns about FAS; also saw David about difficulties with bedtime and interacting with his siblings including violent outbursts; David has ADHD and was assessed for autistic spectrum disorder but no formal diagnosis; Daniel also saw the community paediatrician and has learning difficulties and concerns about FAS; has a history of sleep and behavioural difficulties; assessed for autistic spectrum disorder and like David did not meet the criteria for diagnosis;

The terms of reference

The review considered the impact of the following areas of multi-agency practice in the case to inform learning and future practice:

i. To what extent were established processes and procedures followed in the collating, analysis and processing of information received and disclosures of sexual behaviour between the siblings? Explore how agencies worked together to respond to the information and any concerns identified, whether they were clear about their role and whether the right agencies were involved to protect and support the children. Examine the sharing of information and liaison with relevant health professionals as part of s47 strategy discussions concerning looked after children.

[17] The mother denied drinking alcohol during the pregnancy.

ii. Examine the impact of the children's neurodiversity and learning needs on how agencies responded to the disclosures made. Was there evidence of child focus and the voice of the child influencing how services were provided? Was there a good enough understanding of the lived experience of the children?

iii. Consider the steps taken to protect the children following the disclosures made and whether these could have been strengthened. Include consideration of the impact of the children being looked after and therefore believed to be safe, and also the desire to keep them together as a family unit

iv. Consider the support provided to the foster carers about the circumstances they were being asked to manage to what extent were the foster carers consulted and appropriately supported in collating information about sexual behaviour, understanding the respective children's level of understanding and developing strategies to keep children safe?

v. Examine the role of the Looked After Child review in coordinating the safeguarding and protection of the children once concerns had emerged including;

a) Ensuring an up-to-date statutory health assessment informed discussions about health (emotional & physical) at statutory looked-after review meetings;

b) Information sharing and liaison with relevant health professionals were part of the statutory looked-after review process, including sharing the review documentation and minutes.

vi. To what extent did the Covid-19 crisis impact on either the circumstances of the children or carers or the capacity of the services to respond to their needs?

vii. Examine how the impact of severe early childhood adversity and abuse, disability, language and communication difficulties and culture were considered and factored into the way services responded to the needs of the child and their carers.

viii. Were there any gaps in service that may have led to a different outcome? Were there opportunities to have escalated concerns about the level or the quality of response or service being provided?

Details of the independent author and statement of independence

Peter Maddocks was the independent reviewer. He has not been employed by any of the services contributing to this serious case review.