

23 November 2018

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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to sexual abuse in the family in Cornwall

Between 8 October 2018 and 12 October 2018, Ofsted, the Care Quality Commission (CQC), HM Inspectorate of Constabulary and Fire and Rescue services (HMICFRS) and HMI Probation (HMI Probation) undertook a joint inspection of the multi-agency response to sexual abuse in the family in Cornwall.¹ This inspection included a 'deep dive' focus on the response to sexual abuse in the family environment.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Cornwall.

This joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door', which receives referrals when children may be in need or at risk of significant harm. In Cornwall, this is known as the Multi-Agency Referral Unit (MARU). Alongside this evaluation, inspectors undertook a 'deep dive' into the effectiveness of services for a group of children and young people who have suffered, or are at risk of, child sexual abuse in the family environment. Inspectors also considered and evaluated the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board, known in Cornwall as the Our Safeguarding Children Partnership (OSCP).

There is a strong culture and commitment to partnership-working across the agencies

in Cornwall that are involved in improving practice and services for children at risk of child sexual abuse in the family environment. There is a clear ambition to be innovative, to proactively learn and to provide better multi-agency support and help for children who are at risk of child sexual abuse in the family environment and for children who display sexually harmful behaviour. There are some significant challenges to agencies involved in helping and protecting children in Cornwall due to its geographical isolation, the dispersed nature and smaller size of its communities, and an influx of high numbers of visitors in the summer months. However, this has not impacted on the ability of senior leaders and staff across the partnership to provide and deliver a wide range of services for children who are at risk of or subject to child sexual abuse in the family environment and who need support, help and protection. There is a committed stable and well-trained workforce, most notably in children's social care and health services, where staff morale across the partnership is high.

In January 2018, senior leaders in Cornwall took the initiative to progress, prioritise and improve practice for children who are at risk of sexual abuse in the family environment. As a result of learning from multi-agency audits, they identified that there were areas for development in practice. This has led to some practice improvements, particularly in relation to the more effective use of non-forensic medical examinations for children who have made allegations of sexual abuse.

The OSCP used its existing knowledge and expertise to improve services for children who are subject to criminal exploitation, including learning from police initiatives, to proactively develop a comprehensive child sexual abuse strategy. Since January 2018, a multi-agency task and finish group has progressed developments to operational practice effectively. The child sexual abuse strategy is thorough and provides a useful and informative framework for the partnership to implement this area of practice to meet the full range of children's needs. This is beginning to improve and enhance professional understanding and awareness of child sexual abuse in the family environment. For example, learning workshops in July 2018 and a conference on child sexual abuse held on 24 September 2018 were both well attended by a wide range of multi-agency professionals, who reported improved learning about and understanding of child sexual abuse in the family environment.

There is an established culture in Cornwall of effective direct work and practice with children, and inspectors saw strong and sensitive work from many professionals who are committed to improving support and help for children and their families. There is a wide range of appropriate commissioned services and a strong involvement of schools and of specialist psychological and therapeutic services, such as Jigsaw, which provides individual psychological support to children and their carers. All of this contributes to improved life chances and outcomes for children.

During this JTAI, inspectors found some areas where intervention by professionals could be strengthened and improved. For example, when children are first identified as being at risk, there are sometimes delays in sharing information and risks between partners at strategy meetings in order to inform decision-making. Relevant health partners are not always invited to contribute, and while minutes and actions arising from strategy meetings are always recorded on the children's social care system, they are not always shared between partners and are therefore not recorded on their systems. Inspectors noted a lack of challenge from professionals towards some police decision-making, particularly when considering whether a single or joint agency investigation would be most appropriate in understanding the risks that children may face and in planning effective safeguarding actions. Senior leaders in the partnership took immediate action as a result of the findings of this inspection in order to strengthen and disseminate shared learning for improving processes and practice. While no children were found to be at risk of significant harm during this inspection, some risks to children had not been evaluated quickly enough, or there were avoidable delays in ongoing police investigations.

However, overall the existing partnership arrangements and leadership are strong. Senior leaders have already launched a clear strategic plan and are already progressing developments in multi-agency practice in order to improve outcomes for children who are at risk of or are subject to child sexual abuse in the family.

Key Strengths

- Work in Cornwall to tackle child sexual abuse in the family environment is underpinned by strong and inclusive strategic leadership, modelled by the director of children's services and his leadership team. There are established links between strategic boards, particularly the OSCP and the overarching children's 'One Vision Partnership'. Their priorities to develop and improve practice and services for children who suffer or who are at risk of child sexual abuse are evident in core business. Strong links to the Safer Cornwall Partnership have led to the re-commissioning of the sexual abuse referral centre (SARC) for investigations following allegations of child sexual abuse. The police and crime commissioner is also represented at the OSCP, as are senior health partners. Both police and health partners have provided appropriate resources to address the needs of children who have been sexually abused, including the child independent sexual violence adviser post (ISVA), forensic medical examinations and resources for training.
- Multi-agency partners are supported to improve their understanding of the referral and assessment process through bi-weekly 'open afternoons' in the Early Help Hub (EHH), a multi-agency team of early help professionals, and MARU, where practitioners can observe the hubs 'in action'. This simple yet effective initiative has significantly improved the quality of referrals that MARU

receives, and thresholds for intervention are well understood across the partnership.

- Senior health leaders have worked with partner agencies to recognise and act on areas for development and early identification of risks. This is relevant for all children, including those at risk of child sexual abuse. For example, current waiting times for a Child and Adolescent Mental Health service (CAMHS) assessment are being reduced by increasing capacity, allowing those assessments to be undertaken on a weekly basis with the intention that the current backlog will be cleared by the end of December 2018. The plan is for assessments to then take place within 12 weeks from the point of referral and seven days for urgent referrals. This is on target to be effective from January 2019. CAMHS has previously prioritised higher-risk cases for assessment and therapeutic intervention, which means that lower-risk cases have been offered support from other therapeutic service providers, including those from the voluntary sector. This has meant that CAMHS practitioners have held more high-risk cases per practitioner, which has required more support from managers across the service.
- Alongside this, the multi-agency neurodevelopmental pathway project, as mandated by the One Vision Programme Board, remains on target to meet the needs relating to neurodevelopment conditions for children, young people and their families in Cornwall and the Isles of Scilly. Leaders and practitioners alike are aware of the importance of identifying the needs of children and young people who may be living with an autistic spectrum condition (ASC) or attention deficit hyperactivity disorder (ADHD) in a more efficient and combined way. The pathway is being developed in conjunction with parents, carers and service users.
- Additional resources have been provided by police leaders to respond to the demands of child protection investigations, including child sexual abuse in the family environment. A detective inspector holds a dedicated quality assurance role and regular case reviews and learning events are held to inform operational staff. Two extra detective sergeant posts have been assigned to enhance first stage supervision in child protection investigations.
- Senior leaders prioritise the continuous development of the skills and competence of the workforce in responding holistically to all areas of safeguarding practice, including child sexual abuse. The high-quality training offer from children's social care is available to all multi-agency partners and has been merged with OSCP training, overseen by the OSCP learning sub-group, in order to improve the range and specialism of training delivered. Partners such as the national probation service (NPS), the youth offending service (YOS) and health services have also invested in specialist training to

ensure that their staff are equipped and skilled enough to work with children who are at risk of child sexual abuse in the family environment, children who display harmful sexual behaviour and adult perpetrators. Devon and Cornwall police have a clear training plan to equip and support specialist investigators in their work.

- Health practitioners mostly have good access to safeguarding teams and designated safeguarding professionals, who offer regular supervision, maintain oversight of practice and provide additional support and guidance. Designated health professionals in Cornwall have a good understanding of Cornwall's demographics and how child sexual abuse can present, and they will adapt best practice accordingly to ensure that Cornwall's vulnerable children and young people are protected.
- Police managers understand the benefits of specialist training for child protection investigators. They have identified that problems with the quality of investigation into crimes committed against children are made worse by a shortage of trained officers, and they are dealing with the issue as a priority. They have now trained many of the existing staff and have a system in place that means that all new CID officers are mentored and gain experience of investigating sexual crime and offences against children for a minimum of three months. This supports staff by providing nationally accredited formal training and, with further embedding, is expected to result in better supervision and consistently good-quality investigations.
- The local authority has been successful in creating an environment in which good social work practice can and does flourish. Within children's social care, the professional development system to manage staff learning and development, training and professional competence is highly effective. Consequently, the local authority has created a strong, stable and committed workforce that is proud of the work that it does, and staff morale is high. The local authority is involved in national learning and dissemination of good practice in this area.
- Senior leaders and managers in children's social care have a robust and systematic approach to the use of data and information to fully understand and monitor the performance of services delivered to children. Performance information is reliable and accurate and is used to provide the OSCP and other strategic boards with vital information about the overall performance of the partnership to inform scrutiny and oversight. The system was amended in January 2018 so that all children subject to or at risk of sexual abuse in the family environment could be easily identified. This specific information has now been added permanently to the electronic system to help identify child sexual abuse in the family environment in the future.

- Multi-agency auditing is well established across the partnership. The OSCP has undertaken some thematic audits, and further single agency auditing is regularly undertaken by children's social care, embedding a strong culture of learning from practice. Multi-agency auditing and oversight by the OSCP's quality assurance and performance group and the quality assurance scrutiny panel are thorough and provide further oversight, accountability and learning about the performance of multi-agency partners in relation to their practice to tackle the impact of child sexual abuse.
- Children and families have good access to a wide range of commissioned services to help them come to terms with their experiences. This includes significant investment on the part of the local authority to provide psychological services for children who have experienced sexual abuse. This is making a positive difference to children, families and carers in reducing trauma, understanding healthy relationships and reducing risk. Inspectors saw good use of child ISVAs that resulted in timely and supportive intervention for children. Effective use is made of intermediaries with young children and children with additional learning needs to ensure that they too have a voice within police investigations into child sexual abuse in the family environment.
- We saw some good work undertaken by private and third sector services, such as an outdoor activity centre that uses activities to build relationships between family members, build trust and confidence and change lifestyles so the family have more positive routines. The YOS and NPS are able to provide interventions and services quickly to address harmful sexual behaviour. This is an important contribution to managing risks to children.
- Multi-agency public protection arrangements (MAPPA) are well established and effective. This is a critical contribution to safeguarding children. There is very little suitable accommodation for high-risk sex offenders nationally, and this creates challenges for risk management. The approved premises manager mitigates these risks with timely notifications to police when registered sex offenders are placed, often at short notice. The NPS is robust in managing the risks from perpetrators of child sexual abuse. This includes use of stringent licence conditions, interventions and offending behaviour work, and, where necessary, prompt recall to prison. There is a good service provided by the YOS, the edge of care service known as Gweres Tus Yowynk (GTY) and Gweres Kernow (GK) to support and manage children who display harmful sexual behaviour. They display sensitivity to and understanding of children who are vulnerable and need help and support to prevent further offending, and in reducing risk to others.
- The MARU effectively manages, triages and oversees safeguarding concerns for children. The MARU is a well-established team, incorporating flexible

working so that parents can be contacted in the evening if needed to enable timely progression of work. Thresholds are understood within the partnership. Contacts contain well-researched family histories which aid effective decision-making and planning.

- Decisions regarding referrals are appropriate and timely and proportionate to the level of concern. Referrals focus on individual needs and potential outcomes for children, although the quality is not yet consistently good. Good referrals describe the risks well, whereas others do not give explicit details of the concern, and some are missing key information.
- The police make many initial referrals using a vulnerability information screening tool (VIST). Frontline officers feel that the use of this tool is fully embedded in their safeguarding practice and that it helps to capture the voice of the child. However, inspectors found that, in records held in the system, the voice of the child was marked as 'not applicable' on occasion, missing the opportunity to record a child's lived experience. The police have recently reviewed this deficiency and have altered the form by providing additional guidance for those completing it.
- Within the MARU, effective management oversight ensures that referrals highlighting significant harm are processed quickly, resulting in a timely response to child protection concerns. Social workers make recommendations using the local authority's established method of social work practice well in order to inform risk analysis. All work that is progressing includes details about what the concerns are.
- Social workers recognise risks to children and are aware of the main signs and symptoms of sexual abuse, but there is further work to be done to enable all staff across the partnership to identify the more subtle signs of potential abuse. Inspectors found that there has been increasing recognition of this across all staff groups, but particularly among health and youth offending workers. Escalation processes are well understood in the MARU and are used effectively when necessary to promote the welfare of children.
- Health practitioners at both the EHH and the MARU access specific electronic health patient record systems, but also social care systems and adult mental health systems. This means that those practitioners are well placed to provide detailed information pertaining to whole families in order to aid the decision-making process at strategy discussions in a timely way. Multi-agency partners in the MARU value the contribution that the health practitioners offer and will often use their expertise to identify children and young people from the limited available information.

- Probation officers and YOS case managers understand the thresholds for referral and find social workers helpful and cooperative. There are clearly defined roles between YOS and Social Care. The MARU has a professional role for a single point of contact for the NPS and the community rehabilitation company (CRC), and the person in this position has built up knowledge and relationships to assist with effective information exchange. MARU provides timely information to facilitate allocation at court.
- All CAMHS referrals go through the early help hub, where a CAMHS practitioner is now based, ensuring the timely assessment and consideration of referrals. Children and young people whose circumstances do not meet the criteria for CAMHS intervention are signposted to a wide range of voluntary support agencies. This means that children and young people can access the most appropriate and effective support.
- Records examined in the young people's substance misuse service (YZUP), sexual health services and in some school nursing services demonstrated how the 'Think family' model and consideration of linked adults and children is generally well embedded in practice. This means that risks to 'hidden' children are explored and identified at the earliest opportunity. Records and assessments in the YZUP and sexual health service clearly detail and analyse risk. They capture the voice and lived experience of the child. This means that assessments are holistic in identifying and responding to the needs of the young person and support the practitioners to be professionally curious. This informs the individualised interventions and treatment programmes offered to the young person.
- Effective working relationships between the out of hours service for children's social care and the police ensure that children are safe outside of normal working hours.
- In children's social care, the local authority's preferred model of practice is well embedded and the use of tools to gather children's views and to measure progress means that assessment is responsive to new information and the changing circumstances of children and families.
- Inspectors saw examples where health professionals had gone the extra mile to ensure that children's health needs are met. This was key, given the varied lived experiences of children and their diverse needs.
- A range of targeted assessments are used by the YOS to identify needs and risks. Assessments undertaken by the NPS are thorough and analyse actual and potential risks to children. YOS staff understand how the behaviours of children and young people may be signs of distress, and they strive to

develop trusting relationships so that children can tell them about their concerns. Home visits are used to assess and monitor who is in the child's family environment, as well as who they interact with.

- Schools display a good understanding about the risks to children of sexual abuse in the family environment and to children displaying harmful sexual behaviour. This is evidenced by thorough risk assessments and safety plans. Children are kept safe in school, and schools respond sensitively, displaying high levels of concern for young people's well-being.
- In children's social care, schools and health, inspectors saw evidence of expertise and sensitivity in listening to children. As a result, children who were mistrustful because of their previous experiences are supported to regain their trust in professionals and are therefore empowered to participate in decision-making so that they have a voice. Social workers spoken with understand the children who they are working with and their lived experiences very well. Schools are good at establishing positive relationships with parents and carers, which helps to facilitate ongoing family relationships in the most difficult of circumstances.
- There is good multi-agency attendance and participation in child protection conferences, although the engagement of GPs is less developed. This risks not having access to pertinent information held in the primary care record and could hinder effective multi-agency decision-making. Partner agencies contribute positively to multi-agency meetings, including offering constructive challenge to colleagues and parents where appropriate. However, this challenge is not always escalated appropriately and, on occasion, too much optimism is held about parents being able to make the necessary changes to keep their children safe.

Practice study: highly effective practice

All names are pseudonyms.

A significant strength is the quality of the support given to children who have been subject to child sexual abuse in the family environment, and their families. The range and quality of services available, and clear focus on working with the whole family, support a reduction in the risk of child sexual abuse and make a tangible difference to children's lives.

For Sarah, the sensitive and well-coordinated work of professionals have led to her becoming safer, and her self-esteem, presentation and school attendance improving significantly. We saw some excellent work by psychological services in enabling her to understand healthy relationships, and that she has been abused. This supports work to reduce her vulnerability to abuse and exploitation in the future. The combination of the commitment of professionals, the flexibility of the professionals and coordinated working have been very effective. Sarah has benefited from both direct and indirect support from educational and clinical child psychologists. She has been empowered through her relationships to have a voice and make positive choices.

Sensitive and age-appropriate work with a younger child, John, enabled him to understand and accept why he could not see his father, who is a registered sex offender.

Effective work was undertaken with Michael and his family by an outdoor activity centre that used activities to promote more positive family relationships between family members, build trust and confidence and change lifestyles so that the family have more positive routines. This supported his mother in establishing more appropriate boundaries at home.

Areas for priority action

- There are no areas for priority action

Areas for improvement

- Within the MARU, strategy discussions are mostly timely, but they do not

routinely involve all relevant agencies. Face-to-face meetings do happen in very specific circumstances, such as in hospital, but the right health professionals are not consistently involved in strategy discussions, and this does not enable effective multi-agency decision-making.

- When children experience or are at risk of sexual abuse in the family, strategy discussions do not always take place as soon as the threshold for a discussion has been reached. While this has not prevented individual agencies from acting to help children, responses seen by inspectors were sometimes not well coordinated and sometimes delayed and did not always result in effective medical checks or response. Where a child's case is already open to children's social care, new information is often referred direct to the allocated social worker, and this does not always then result in a strategy meeting taking place as soon as it should. Inspectors found examples of missed opportunities to assess and intervene earlier for these children, but also for siblings, other connected children, suspects and the wider public.
- Risks posed by registered sex offenders to their children are not always fully identified quickly enough by police and probation staff. This leads to delays in strategy discussions taking place and actions to reduce risk. Local NPS leaders are aware that, in future, when adult offenders are released from prison and plan to move to Devon and Cornwall, rigorous challenge and scrutiny of any such plan must be undertaken.
- Outcomes of referrals and subsequent strategy decisions are not always fed back to partners, and they are not proactively followed up by agencies involved. This means that agencies have not always effectively communicated whether risks to children have been mitigated, and there has not been a jointly shared record of the strategy discussions and agreed actions for investigations. Senior leaders within children's social care took immediate action to rectify this issue.
- A lack of effective challenge between agencies and professionals has sometimes resulted in decisions to undertake single agency child protection enquiries when a joint agency enquiry by police and children's social care is required. This means that investigations have not routinely had the benefit of the expertise and knowledge of the police from the onset, which has potentially led to delays in evidence gathering and criminal prosecutions.
- Delays in criminal investigations, such as delays in arresting or questioning suspects of sexual abuse even when there may be a rationale, and the use of the voluntary attendance of a potential perpetrator at a police station, or delays in the forensic examination of digital equipment, can mean that investigations take a long time and can impact on children's well-being.

- Police engagement with children is an area for development. For children who are sexually abused, what they say when they first disclose what has happened to them is sometimes taken at face value. Time is not taken to work with these children to help them to understand how best they can be protected. For a small number of children, decisions have been made that are not always in their best interests. In one instance, inspectors noted that this included not informing parents, or not speaking to perpetrators when the child has said they did not want this to happen.
- For one child who displayed sexually harmful behaviour, inspectors found that there was a lack of urgency in responding to specific practical and therapeutic needs and a lack of an immediate suitable placement.
- In relation to information-sharing across the partnership, the use of flags to improve professional understanding of risk is in place. For example, police systems support officers attending incidents by alerting them to some risk by using flags, but this is inconsistent, so flags are not visible in some cases where risk is known. In health records, alerts and flags are generally used well to increase the visibility of children who are looked after, or who are the subject of child protection plans, and to inform health staff in providing their ongoing care. However, the family composition and demographics section of records and chronology of significant events templates do not always accurately reflect the changing risk and circumstances of children, which hinders effective tracking and oversight of needs.
- Safeguarding practice when adults attend the emergency department at the Royal Cornwall Hospital (RCH) was seen to be too variable, especially when their attendance is because of risk-taking behaviours such as substance misuse. Staff use a prompt to ask if an adult has caring responsibilities for children or vulnerable adults, but this prompt does not consider contact with children, for example siblings or a partner's children. In addition, the limited prompts to encourage practitioners to ask those questions are not always carried out. Professional curiosity was not apparent in the GP records viewed. GPs do not routinely question the child to ascertain additional information when risks are identified and none of the general practices used any national tools, such as 'spotting the signs'.
- Information governance arrangements in RCH are under developed, resulting in information being stored in different places. This increases the risk of safeguarding information being missed. There is an additional risk for pregnant women who may attend the emergency department because staff do not have access to safeguarding records. Furthermore, records and assessment templates completed by midwives do not prompt the midwife to

ask and consider childhood experiences of the pregnant woman or her partner. This leads to an over-reliance on professional curiosity, which was not evidenced in this regard in the records reviewed.

- Child exploitation risk assessment tools are not completed by nurses or midwives in RCH unless part of a MARU referral. The under-18 proforma in the emergency department includes prompts to aid practitioners to identify risks, but these are not consistently completed. Therefore, a risk remains that some children's needs and vulnerabilities are not recorded or identified. However, a member of the RCH safeguarding team will attend meetings, including strategy discussions, when requested to do so.
- There is no routine liaison between the sexual health services and other health services, including CAMHS and YZUP, or liaison to attend wider partnership meetings, such as the missing and child exploitation forums (MACE) in order to improve information-sharing. The sexual health hub and the Brook sexual health service are not invited to attend child protection conferences or requested to submit reports. This limits wider understanding of a child's needs and risks.
- There have been delays in YOS involvement in some cases, caused by late receipt of notices from the police asking the service to engage with children who had committed an offence, resulting in late assessment of risk and needs.
- In the wider partnership, further work is needed to consistently involve parents and children prior to referrals being made to MARU. This issue has been identified by the police and the RCH, and there are plans to resolve this. Practice is stronger in social care and the YOS, and referrals do not proceed without the consent of parents unless it is in the best interests of the child to do this.
- Multi-agency planning does not always focus enough on reducing the risk of sexual abuse and planning for the future. This is in part due to child sexual abuse in the family environment not being recognised as the main risk and the focus being on other abuse, such as emotional harm or neglect. This can result in agencies that could provide information and additional support not being part of the plan.
- While social work assessments acknowledge sexual abuse, they do not consistently consider this within the analysis of the child's current lived experiences, particularly when abuse is historic. This limits the consideration of the impact of past abuse on the child's current circumstances.

- Social care child plans are not started until social work assessments are completed, despite support being provided during the assessment. This means that plans for children and families can't be shared with them or with other professionals, as this is not clearly recorded, other than in case notes. Therefore, the level of work being completed is not always clear on an ongoing basis, and it is difficult to determine children's progress against agreed actions.
- Despite the review of specialist training and plans to train all staff involved in child abuse investigations within the Devon and Cornwall police, some staff in key positions have not yet received the relevant specialist training. On occasion, the prioritisation of cases was not fully effective. Ensuring that all staff receive relevant specialist training may help to improve effectiveness in this area.
- Positive activity to improve training and supervision within Devon and Cornwall police has yet to translate into consistently good practice. There are shortfalls in the quality of investigative planning within police case work, which directs activity in a timely way. In the cases examined, inspectors saw little evidence of meaningful supervision that set priorities and evaluated risk in relation to the victim, the offender and other children. We found poor recording of strategy discussions and later meetings that considered the child's experience, and a lack of active supervision with little recorded rationale for the most appropriate means to manage evidence gathering, witnesses and suspects. The impact of poor investigations is that children who have told their story with the expectation that they will be protected may remain at risk of harm and that strategies to prevent offending behavior are undermined.
- While school staff understand the need to plan and where possible to provide therapeutic support for children subject to sexual abuse in the family environment and to ensure that those displaying harmful sexual behaviours get the support they need, this is not always being planned for or provided. In a minority of cases, the school staff were at a loss as to how to ensure the support was suitably tailored to meet the children's individual needs.
- Some health assessments and plans completed by health staff are delayed, lack specificity and professional curiosity, and the language used weakens the impact of the child's lived experience. While swift notification processes between the local authority and the children in care health team are in place, the timeliness of initial health assessments is too inconsistent, and in one case seen was outside of statutory timescales. Delays are evident in the sharing of health action plans following initial children in care health assessments.

- Due to high demands within the school nursing service, some entries in school nurse records are not made contemporaneously and explanations for the delay in making entries are not always given. This is not best practice and risks the record not accurately reflecting the changing needs of the child or the care given.
- Within the early help strategic plan, there is a missed opportunity for greater involvement of community policing in the early help hub in order to integrate preventative policing responses with other partnership activities, which would improve the alignment of neighbourhood policing with the local authority and health early help offer.

Practice study: area for improvement

A key area for development is that risk is not always fully identified, leading to some delays in taking timely action to safeguard children. The risk of registered sex offenders to two children was not fully identified because there was not sufficient challenge by professionals about the risks involved. For a further two children, though risks were identified to the children who had disclosed abuse, risks to other children who were potential victims and children who have displayed sexually harmful behaviour were not identified and responded to in a timely way. However, at the time of the inspection action had been taken to ensure that these children were being appropriately safeguarded.

In the case of Mark, who is aged four, risks from his father who is a registered sex offender and at this time was in prison were not effectively considered and resulted in delays when there had been opportunities to assess and intervene earlier. This led to Mark's father inappropriately moving home for a period after release from prison.

Risks were subsequently identified, and action was taken to safeguard Mark.

In the case of Alex, a referral was made in relation to the sexual abuse that he had experienced. However, there was delay in acting to fully assess the risks posed by the 16-year-old suspect committing offences against him. Risks to another child, and the suspect's siblings, who are children, were not considered swiftly enough, and this led to delays in appropriate safeguarding action being taken in order to protect these children.

In the case of Julie, a child with physical and learning disabilities, who was a victim of a sexual assault by another child, there was a delay in completing an assessment with an intermediary. Following the delayed assessment, it was decided not to proceed with an achieving best evidence interview. While both children were safeguarded, the case planning did not sufficiently prioritise intervening with the young person who was the perpetrator and who was displaying sexually harmful behaviour. It also undermined evidence-gathering and planning to support safeguarding for both children.



Care Quality Commission



Next steps

The local authority should prepare a written statement of proposed action responding to the findings outlined in this letter.

The response should set out the actions for the partnership and, where appropriate, individual agencies²

The director of children’s services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 6 March 2019, 70 working days from pre-publication. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	Care Quality Commission
 Yvette Stanley National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	HMI Probation
 Wendy Williams Her Majesty’s Inspector of Constabulary	 Helen Davies Assistant Chief Inspector

² The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/ukxi/2015/1792/contents/made enable Ofsted’s chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.