Gwent Safeguarding 7 Minute Briefing

Child Sexual Abuse and re-victimisation: Child Practice Review (Children H)

What to do Learning Opportunity

Reflect on the case discussed and think of how this situation could have presented in your work with vulnerable individuals?

Ask Are there any similarities in cases you have worked or situations you have encountered? Are there clear thresholds between agencies and pathways to address conflict?

What would you have done in a similar situation when working with vulnerable individuals? And what are the barriers to practice in your organisation?

Identify key support for yourself in your team.

Briefing

In December 2015 SEWSCB published an extended child practice review in respect of a sibling group of 4 children, 2 boys and 2 girls

This Briefing will look at the published review and will aim to highlight the learning from the findings.

It is important to note that this briefing is a concise summary of learning and not a full copy of the report. The report in full can be accessed using the web link in the footer of this document.

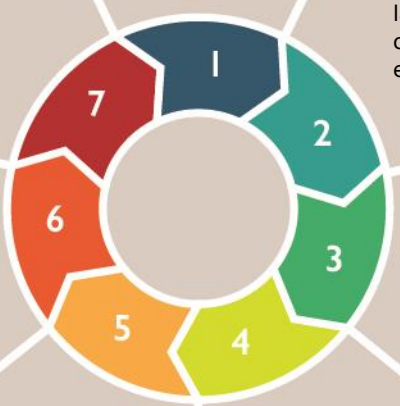
Background

The family had been known to services since before the eldest child's 1st Birthday. The concerns at this time were in relation to Domestic Abuse, sub optimal home conditions and Neglect.

As the family grew concerns expanded to include an incident of physical abuse, this led to the 1st period of Child Protection Registration

By the time the eldest child was 11 years old, a police investigation uncovered evidence that the two girls had been sexually abused by extended family members, this lead to conviction and custodial sentences for the abusers.

Shortly after the sexual abuse was uncovered a second period of registration commenced, this lasted for 8 months. During this period the children continued to experience neglect and exhibit escalating aggressive and sexualised behaviours.



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Despite the evidence of sexual abuse within the family the impact on the boys was not considered neither was the opportunity for the girls to receive specialist support over generic CAMHS. It was felt that whilst disclosures were made by the children in therapy this was not shared appropriately to partner agencies and the balance between therapeutic relationships and safeguarding was lost. Information sharing was hampered by a lack of confidence in partner agency abilities to manage the information presented.

Parental behaviours were not considered in the context of disguised compliance and were not effectively challenged. Short term improvements were given more weight than the presence of persistent neglect.

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Subsequently the eldest female child disclosed that she had been sexually abused by another adult male extended family member. This allegation did not proceed to trial due to the emotional fragility of the child. It did however lead to a third period of child protection registration during which an anonymous referral in respect to the treatment of the children by their mother was received by the Local Authority.

This resulted in the children being accommodated under section 20 of the Children Act 1989. They currently remain in Foster Care.

Summarised Findings

Reviewers found that through the children's involvement with services practitioners rarely spoke to them alone. Discussions often took place in the presence of parents who were perceived to be disruptive.

The aggressive and sexualised behaviours of the children were not assessed in context and it appeared that professionals lacked the skill to identify behaviours as possible indicators of sexual abuse, as such opportunities were missed.

One such missed opportunity was the lack of consideration of a child protection medical, particularly as one female child had reported vaginal blood loss that was incorrectly attributed to menstruation. Neglect and physical abuse were not identified and risk assessed as a possible factors in relation to sexual abuse. Partner agencies felt that their information was not given the weight that it deserved, yet despite this the resolution of the SEWSCB Professional Differences Guidance was either not evoked or was ineffectual when applied.

Key Learning

The following Key learning was identified by the review:

The importance of the voice of the child,

Physical abuse and neglect, risk of sexual abuse and re-victimisation,

Interagency Information sharing,

The use of child protection medicals,

Making use of guidance and policies

Assessment and analysis.

The following web link provides you with access to the full Child Practice Review report:

http://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/SEWSCB_Child_Practice_Review_Report_Case_H.pdf