Child DQ 7 Minute Briefing

Salford Safeguarding Children Partnership

1. Background

Child DQ had been known to services since the age of 5. Her Mother had previously struggled with drug abuse, mental health and had made poor relationship choices. As a result, DQ had at times been supported by CIN and LAC and had lived with other family members. When DQ was 14 years old she decided to return to her Mother's care. Mother was pregnant with the child of S but the relationship had ended.

It was a unanimous decision by agencies to support DQ moving back with her Mother under a CIN plan. DQ was particularly vulnerable as in addition to her chaotic childhood she had been victim to sexual abuse. Mother and DQ engaged with the support and following a pre-birth assessment, unborn sibling was also made subject to CIN.

There were now 2 children subject to the plan with very different needs and it was agreed that DQ's plan could be discharged prior to sibling being born. DQ did not feel that she still needed a plan and agencies were reassured that she would continue to have support as work would continue with the family under sibling's CIN.

2. Safeguarding Concern

DQ's plan focussed upon DQ's return to her Mother's care but a risk was also recognised in regard to S who Mother described as having been controlling and who CSC knew was a substance abuser who suffered mental illness.

This risk was addressed by use of safety plans. The safety plans took into consideration learning needs of DQ and were written in plain English with easy to follow instructions. They outlined the expectations of both DQ and Mother if S was to make contact. A challenge within the plans was that their success was reliant upon DQ understanding the risk that S posed and being open and honest with Mother. All agencies knew of the plans and shared responsibility, but S was unaware of them.

Throughout the time period specified for this review, S was involved with several community teams within GMMH and was admitted to inpatient mental health services on three occasions. S had presented, and continued to present, with both intimidating demeanours and sexually inappropriate behaviour. This was not reported to the police and not shared within any risk assessments.

3. Incident

Around the time that sibling was born, DQ had a chance encounter with S. Although she had previously followed the safety plan and informed her Mother of any unexpected meetings, she did not tell Mother on this occasion and she remained in contact with him via social media.

This contact resulted in her visiting S at an address, where he offered her alcohol before raping her. DQ disclosed the rape to her Mother and cooperated with a police investigation which resulted in S being convicted of the offence.

4. Findings

- SW's should be adequately trained to skilfully chair CIN meetings which consider and address the different issues and needs of multiple children, without causing confusion for the family.
- It is essential to communicate the reasons and benefits of risk assessing a parent who has been absent from a child's life to the carer of the child, so that they understand the importance of being open and honest with professionals if the absent parent attempts to make contact.

- It is crucial to the success of a safety plan that all the agencies involved take responsibility for monitoring their effectiveness.
- A safety plan is stronger when all the parties involved are aware of its existence and understand its necessity.

5. Findings cont.…

- A young person who has experienced sexual abuse will require ongoing support as they mature.
- Risk assessments must always include an up to date reflection of risk and include an individual's risk to others and to themselves.
- Staff should be supported to report and proactively respond to sexual incidents.
- Staff should not become desensitised to sexual behaviours and should keep a focus on the potential victimisation of others.
- When it is suspected that a person who poses a risk could be associating with children – practitioners need to maintain professional curiosity and productive information sharing is essential.
- Staff should always give consideration to historic parenting patterns, and the ability of a parent to meet a child's needs when under pressure, before stepping down from any protection plan.

6. Recommendations

The SSCP to ensure that all practitioners understand the importance and significance of historic parenting patterns when considering thresholds for protection planning. This is to be addressed by means of training and supervision.

The SSCP to seek assurance from partner agencies that safety plans will be shared with all parties and that this will be considered even in the absence of consent, unless not appropriate to do so.

The SSCP and its partner agencies to ensure that any child subject to sexual abuse is offered safe and healthy relationship work and ongoing support.

7. Implementing Change

Reflect on the findings and discuss the implications for your service.

Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations.