

## OSCB AUDIT (September 2018)

The focus of this audit was to independently examine the effectiveness of joint preventative work with young people displaying harmful sexual behaviours. The topic was selected by VOXY in response to their own experiences and issues arising in schools amongst their peer group.

### About the Audit

The objectives of the audit were to:

- Establish whether young people who have perpetrated abuse to children have been known to services
- Identify the issues these young people experienced within families and review if agencies had an understanding of their effect on the young people
- Review services involved and the impact of their involvement.
- Analyse the quality of professional assessments and identify what we can do to improve outcomes.
- Review the quality of information sharing and communication.
- Identify information and tools that might help practitioners and managers in assessing information which informs decision making.

### Scope

Five young people were identified by the Kingfisher team. The cases involved peer on peer abuse, had involvement with Kingfisher team within the last 2 years and were educated in Oxfordshire. These cases concerned five young males under the age of 16.

**Note:** Due to the small number of cases audited it is not possible to draw conclusions on risk factors and multi-agency working in general. The findings are therefore presented as a 'snap shot' with key messages and learning points.

### Snap shot on the five cases

All cases were known to specialist health services. Three cases had a 'Team Around a Child' (TAC) in place at certain stages of their life, two were on Child in Need (CIN) plan during their life and there were no case had been subject to a child protection plan. Two cases were known to Youth Justice Services.

The findings highlighted that the majority of these children had additional needs and that fire setting was a prominent feature. It is proposed that the findings are shared with the Disabled Children's services as well as the Fire and Rescue Service.

### Key Messages

#### 1. Adverse childhood experiences.

Shared characteristics across the audited cases: diagnosis of ADHD, SEN, poor school attendance and use of exclusions to manage behaviour, fire-setting, enuresis, carrying knives, viewing of violent or sexually explicit imagery, drug use and the risk of CDE. In addition, parental mental health, domestic abuse, substance misuse and neglect were apparent in all cases.

#### 2. Assessments.

Multiple referrals for help did not always lead to assessment. When undertaken, auditors could not see that assessments were able to convey a good understanding of what impact the young person's family life had on their behaviour. Multi-agency chronologies could have supported assessments and risk management.

#### 3. Interventions.

Interventions were not sustained. Where the young person or family did not engage, their case was closed rather than escalated. There was no evidence of consistent positive role models or one professional consistently supporting them - "Every child needs at least one adult who is irrationally crazy about him or her".

#### 4. Information sharing.

Information was shared well but there was not one agency holding all the information on the children. The cases were complex but this was not fully understood or 'owned'. It was also less evident that education partners had the same understanding of the young person's safeguarding context.

#### 5. Listening.

We can do more to ensure that the voice of children is captured and shared.

#### 6. Keeping children safe in education.

The audit highlighted the importance of engaging the child in learning. Keeping children safe in education was not always a priority because of competing concerns regarding their general welfare. It also highlighted a gap in practitioner understanding of types of schooling e.g. home schooling, reduced timetables etc.

## Audit Conclusions

### Neglect and older children

The audit indicated that these young people had had a range of adverse early childhood experiences which have impacted on them as they have grown up.

The audit's 'multi-agency view' has highlighted that signs of neglect were not necessarily identified early and responded to in a co-ordinated manner as they became older.

### Assessing young people with harmful sexual behaviours in the context of 'contextual safeguarding'

This audit reinforced the view that older children still need parental care, support and guidance and that it was difficult for agencies to support families to achieve this well due to the complex family difficulties, lack of engagement and a joint shared agency approach.

The audit also highlighted that it was important to consider the risks and actions of these young people in terms of contextual safeguarding.

## Audit Recommendations

1. Raise awareness of contextual safeguarding and a shared approach to complex cases.
2. Promote better documentation of the 'voice of the child'
3. Promote the use of multi-agency risk assessment and management plan (MARAMP).
4. Ensure the work to keep children in full-time education is delivered and has an impact on school attendance amongst children with special educational needs.
5. Raise awareness of the long-term impact of neglect on adolescents and promote the use of the multi-agency chronology.
6. Develop a summary sheet and ensure that learning is shared with key partners including services for disabled children and fire and rescue.

## Following on from the audit recommendations; what can we all do now?

See [here](#) for information on the Contextual Safeguarding framework and resources.

Be aware of the [MARAMP](#), designed for use where there are concerns about a child or young person linked to 'risky behaviours'.

Ensure you see and speak to the child, actively listen to what they say and take their views seriously.

Use the guidance and resources available via the [Neglect Practitioner Portal](#), including [Multi-Agency Chronology Guidance](#).

Be aware of the [pathway](#) for referring or escalating high risk/'stuck' cases to the [Complex Case Panel](#)

See the [Practitioner Toolkit](#) for further information and tools for issues arising in work with children, young people and families.

See [here](#) for NSPCC information, guidance and resources on harmful sexual behaviour.

See [Growing Up Neglected: a multi-agency response to older children](#)

Glossary			
VOXY	Voice of Oxfordshire Youth	OSCB	Oxfordshire Safeguarding Children Board
ADHD	Attention Deficit and Hyperactivity Disorder	SEN	Special Educational Needs
CDE	Child Drug Exploitation	CSE	Child Sexual Exploitation
Kingfisher Team	Oxfordshire's Specialist CSE Service	TAC	Team Around the Child
CIN	Child in Need	MARAMP	Multi-Agency Risk Assessment and Management Plan