Serious Case Review: John

Learning Summary

Synopsis of the case review process & case information

The Serious Case Review (SCR) examined the involvement of agencies and services with a young adult, who for the purposes of this review will be known as John. Information came to the attention of the Safeguarding Partnership when John was a young adult about issues relating to his childhood and adolescence which indicated opportunities had been missed to provide support and protection for John, but also effectively manage risk. Following a Rapid Review, a thorough and systematic SCR was undertaken, led by an experienced Independent Reviewer – Kevin Ball. A Review Panel was established to support the smooth and timely completion of the review and comprised of representatives from key agencies involved with John. The review began in May 2022 and concluded in October 2022. Those that had worked with John were given the opportunity to contribute. John and his mother have contributed to the review.

John and his mother had contact with some agencies from birth due to maternal mental health concerns but also, and more significantly, due to the emerging problems John's mother experienced managing his behaviour from an early age. Concerns steadily emerged about John having neurodiversity issues that required regular and ongoing support. As John got older and moved into adolescence, the behaviour he exhibited from these issues also created challenges for educational professionals, but increasingly for John, who was on a harmful pathway; this harmful pathway caused John to be at risk himself but also pose risks to others. A multi-agency chronology indicates multiple times when John came to notice of agencies due to welfare related issues or potentially harmful sexualised behaviour including Children & Family Community Services, the Police and the Children's Convenor.

Key local learning identified as a result of the review

Early identification, plus early & targeted intervention are important in helping children through childhood, transition positively into adolescence and onto adulthood.

Information provided strongly supports the importance of the early identification of child welfare concerns, timely support and help being provided to parents in order to prevent the further emergence of worrying behaviours and pathways to further harm. Opportunities did exist for this to happen in respect of John's childhood but were not maximised. Positively, issues of concern relating to his poor concentration and impulse control which was impacting on his educational progress were identified at pre-school and led to John's educational needs being recorded on the Special Educational Needs Register and additional input being provided. John was able to show good attendance at school in these earlier years, and did

make progress however on reflection, he felt that the support provided was insufficient to help him remain in the classroom on many occasions and that some school staff did not appear to understand his needs or how to manage him.

As a pre-teenager, John had been diagnosed with neurodiversity issues demonstrating his complex level of need; John could clearly have been categorised as a Child in Need in his earlier years and benefitted from structured support with a multi-agency footing. Welfare concerns largely appear to have been dealt with on either an episodic basis or by being 'treated' through a medical model of intervention i.e., the use of medication. These neurodevelopmental diagnoses added layers of complexity about how to manage his behaviour, and an earlier coordinated multi-agency approach, with a strong lead, would likely have provided opportunities for oversight and support in an attempt to steer John onto a more positive adolescent pathway.

Balancing the needs of children who are at risk, or have high levels of need, alongside managing them when they pose a risk to others & not unnecessarily criminalise them, is a perennial practice dilemma.

Information submitted indicates that from pre-teenage and into older adolescence, John's conduct became increasingly more worrying in terms of harmful sexual behaviours. The Health & Social Care Service have reflected that many meetings were taking place led by different agencies with lots of 'noise' about John and the risks he posed. Some risks were seemingly recognised but that it was 'someone else' who would be doing the work. This view was supported by all on the Review Panel and agency representatives.

With the benefit of hindsight, agencies have highlighted that service delivery must be child centred, holistic and systemic – features that were not wholly present in this case. It is apparent from review that matters were often crisis driven and fast moving with concerns for victim safety leading investigations and interventions, but opportunities to intervene using established systems and processes not being used to support and protect John. In this case, John was not considered to be the victim of abuse; but treated as the offender. Children who display harmful sexual behaviours should be subject to child protection processes including individualised Strategy Meetings in their own right. Consideration should be given to their unmet needs and potential child protection interventions in order to safeguard and promote their welfare as well. This way, the child can be viewed as a whole rather than in relation to the alleged offences they may have committed. Clear and explicit interagency procedures to support safeguarding practice on the island, in respect of harmful sexual behaviours, should be prioritised.

Assessment of risk & safety planning, in cases of potential harmful sexual behaviours, needs to be viewed as a multi-agency activity but with a clear lead role coordinating the combined efforts of all professionals involved.

The more complex the issues, the greater likelihood of needing a strong, multi-agency and strategic approach to risk management. Agencies supported the view that information sharing across the multi-agency network, especially about risk factors that were being identified, was not always consistent, and exercising curiosity about symptomatic behaviours, such as running away and not attending school, is important when trying to understand what might be happening; dealing with episodic crises is necessary, but examining the underlying causes is equally important. There was consensus that risk assessment needed to be seen as a continuous and dynamic activity rather than static and stand-alone.

There is little information to indicate a coordinated and comprehensive assessment of risk across all of the key agencies that were involved with John, particularly during his adolescent years when concerns began to escalate. Silos of assessment were carried out, and silos of information were held by agencies and not effectively joined together or not judged to be at a threshold that prompted a multi-agency safeguarding approach to be considered. By the time John's conduct had reached a criminal threshold and his sexualised behaviours had escalated, he was viewed as an offender – by which time taking a backward step to consider his own unmet needs and the origins of his behaviour, were too late.

This review has acknowledged a recent audit conducted by the NSPCC regarding harmful sexual behaviours. Positively, this indicates proactive steps being considered by the Partnership to harmful sexual behaviours on the islands prior to the circumstances of this serious case coming to the attention of the Partnership. However, this review has highlighted the need for pace and momentum now in implementing and embedding the actions from that audit. Ongoing professional development, knowledge and skills were strong findings from all agencies that participated in this review. Of particular relevance, and in line with the findings of this review, the audit notes the importance attached to improvement activity needing to be a partnership effort ' … [the] *action plan is multi-agency – no single agency can improve the experience of children and young people who display harmful sexual behaviours in isolation. To be successful, buy in and commitment from all sectors and agencies is critical …*'.

Supporting young people that have experienced adversity in their lives, and who go on to follow negative pathways through adolescence, is achievable by developing meaningful & trusting professional relationships.

The efforts of the Youth Justice Team appear to have been fruitful in forming an enduring relationship with John due to persistence and tenacity. Both John and his mother were complimentary about those that spent time listening to her concerns and took time to get to know John; this included some psychiatric nurses. John and his mother commented that they

felt those in authority i.e., the Police or criminal justice agencies, were not doing enough to prevent him from getting into trouble, with John describing that he would consciously push the boundaries to see their response. Having reflected on his adolescent years he described being bored as a factor, resulting in him getting into trouble, taking more risks and agencies being too lenient with him. These views do reflect the practice challenge of balancing, or being proportionate, and not wishing to unduly criminalise or penalise young people whilst providing support and guidance.

Recommendations

As well as actions identified by each agency that contributed, the review concluded with four recommendations for the Partnership to strengthen and improve working arrangements to safeguard and promote the welfare of children.

1. The Partnership's 2019 Information Sharing Guidance for practitioners providing services to children, young people, parents and carers should be reviewed by explicitly naming all the signatories of the guidance so that it carries greater authority and weight. It should also be strengthened with practice examples to aid professional understanding about when information can legitimately be shared. Once revised, it should be disseminated to all relevant agencies and briefing sessions provided to front-line practitioners and managers.

2. The Partnership's on-line procedures should be reviewed and, where necessary, strengthened to reflect practice relating to harmful sexual behaviours and specifically the practice challenges for professionals when responding to those children & young people who are victims of abuse but also pose a risk to others. Review should involve consideration and guidance about how to manage individual cases via the different procedural pathways, as well as potentially developing specific guidance with a dedicated tab about the particular challenges and dilemmas it brings.

3. The use of professional challenge and escalation guidance should be further promoted to all professionals.

4. The Partnership should continue to oversee the implementation of the action plan arising from the NSPCC audit, and should work together to identify, and where possible remove, any barriers to implementation.

February 2023

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