Safeguarding Adults Board
LEICESTERSHIRE & RUTLAND
Safeguarding Children Partnership
LEICESTERSHIRE & RUTLAND
Leicester Safeguarding Adults Board
WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE
Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE

# Safeguarding MATTERS

Issue 33
October 2024

P2 The role of the Safeguarding Children Partnerships in identifying and disseminating learning
P3-8 7 Minute Briefings -
P9 "Invisible"/"Hidden"/"Unseen" Men: Engaging fathers and male carers in effective practice
National Child Safeguarding Practice Review Panel
P10-11 Impact of parental cannabis use on children
P11 NSPCC – National Case Review Collection and Learning from Case Review Briefings
P12 Leicester and Leicestershire & Rutland Safeguarding Children Partnerships Procedures Manual updates.

**SPECIAL ISSUE**
**Learning from safeguarding children reviews and audits**

## Welcome
to the latest edition of Safeguarding Matters.

**This is a special issue focusing on learning from safeguarding children reviews and audits that have been undertaken across the Leicester and Leicestershire & Rutland Safeguarding Children Partnerships. There is also information linking to national themes and safeguarding priority areas.**

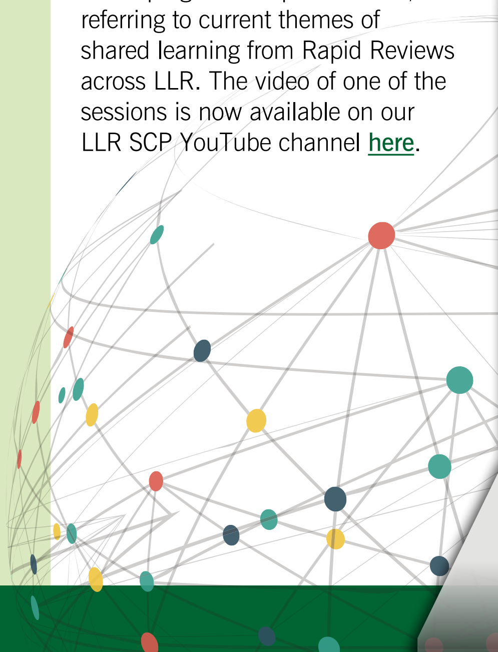
While the focus is on safeguarding children themes, we would encourage all practitioners to read this issue in line with a **Whole Family** / **Think Family** approach.

## The Curious Practitioner:
### Learning from Reviews – Training video

**In September 2024, the Leicester and Leicestershire & Rutland Safeguarding Children Partnerships ran training events to share some of the learning from Rapid Reviews that had identified similar or the same learning across Leicester, Leicestershire, and Rutland (LLR). The events were open to anyone who works with children and families across LLR.**

Where there is a referral about serious harm to or the death of a child and there is abuse or neglect suspected or known, a Safeguarding Children Partnership will first conduct a Rapid Review. A Rapid Review is a multi-agency process which considers the circumstances of the referral. The purpose of the Rapid Review is to identify and act upon immediate learning and consider if there is additional learning which could be identified through a wider Local Child Safeguarding Practice Review (LCSPR). If no further learning is identified then a LCSPR might not be conducted. Whilst Rapid Reviews are not published, the learning needs to be and is shared.

At these events, the focus was on developing curious practitioners, referring to current themes of shared learning from Rapid Reviews across LLR. The video of one of the sessions is now available on our LLR SCP YouTube channel here.



# The role of the **Safeguarding Children Partnerships** in identifying and disseminating learning

**The statutory guidance, Working Together to Safeguard Children 2023, notes that Safeguarding Children Partnerships "play an integral role in establishing a system of learning and reflection locally". The Leicestershire & Rutland Safeguarding Children Partnership (LRSCP) and Leicester Safeguarding Children Partnership Board (LSCPB) fulfil this role by identifying and disseminating learning from reviews and audits.**

They assess serious child safeguarding cases, defined by Working Together 2023 as *"those in which:*

- *abuse or neglect of a child is known or suspected*
- *the child has died or been seriously harmed."*

The LRSCP and LSCPB consider these cases and, where required, undertake a Rapid Review and decide if the criteria for a Local Child Safeguarding Practice Review (LSCPR) have been met. Working Together 2023 highlights that meeting the criteria does not mean a Local Child Safeguarding Practice Review must automatically be undertaken. Instead, the process should determine whether a review is appropriate (i.e. whether there is potential to identify improvements). The purpose of a Local Child Safeguarding Practice Review is to explore how practice can be improved through changes to the system itself. Even if a LSCPR is not commissioned, there is often learning from a Rapid Review which will be taken forward to drive improvements for outcomes for children.

Rapid Reviews and decisions around cases are sent to the Child Safeguarding Practice Review Panel. They may propose a National Child Safeguarding Practice Review. They state that "The national reviews we commission may be thematic reviews based on types of cases or systemic issues that we see frequently or are identified as important national issues, or they may be individual case reviews where a particular case is significant in terms of its complexity or implications for national learning."

All reviews will be proportionate to the circumstances of the case and focus on the potential learning. The child will always be placed at the centre of the process.

As part of their role in analysing quality assurance and service improvement, the Leicester and Leicestershire & Rutland Safeguarding Children Partnerships also carry out multi-agency audits on themes of both local and national importance.

Locally, learning from Rapid Reviews, LCSPRs and multi-agency audits is disseminated in numerous ways, including via 7-Minute Briefings, the Safeguarding Matters newsletter and Live events and the multi-agency training programme provided by the Leicester, Leicestershire & Rutland Safeguarding Children Partnerships.

# 7-Minute Briefings

Learning in seven minutes is manageable in most services, and learning is more memorable as it is simple and not clouded by other issues and pressures. Clearly such short briefings will not have all the answers, but it is hoped that they will act as a catalyst to help individuals, teams and their managers to discuss and reflect on their practice and systems.

We produce 7-Minute Briefings to disseminate learning identified in Rapid Reviews, Local Child Safeguarding Practice Reviews (LCSPRs), multi-agency audits and nationally. We encourage all individuals and agencies to record or evidence how they have used our 7-minute Briefings. A 7-Minute Briefing Action Plan Template is provided here.

The following 7-Minute Briefings presented cover the following topics:

- A Multi-Agency Case File Audit on Pre-Birth Planning
- Multi-agency working around children under Local Authority care
- Working with families where there has been parental separation
- Consenting sexual relationships
- Young people who self-harm and/ or take their own life
- Supporting Disclosure of Child Sexual Abuse

The whole range of local 7-Minute Briefings available can be found here: https://lrsb.org.uk/7-minute-briefings

See pages 3 - 8

Contents ▶

# 7-Minute Briefing – Multi-Agency Case File Audit on Pre-Birth Planning

Safeguarding Children Partnership LEICESTERSHIRE & RUTLAND

Leicester Safeguarding Children Partnership Board WORKING TOGETHER TO KEEP CHILDREN SAFE

## 01 Purpose of this Briefing

A deep-dive multi-agency case file audit, focusing on Pre-Birth Planning, was carried out by the Leicester and Leicestershire & Rutland Safeguarding Children Partnerships (LLR SCPs) between May and September 2023. This briefing shares the good practice and learning identified.

## 02 Background to Audit

This theme was agreed to support the Safeguarding Babies business priority and in light of learning from local Rapid Reviews. It considered whether services complied with, and applied, the LLR SCP procedures including thresholds, partner identification and service response to the unborn/born child via pre-birth planning.

## 03 Audit Scope

The group of babies was identified for review based on cases where the expectant parent/s had previous children removed from their care. A total of 12 cases were reviewed – 5 from Leicester City, 5 from Leicestershire and 2 from Rutland.

## 04 What worked well

There was evidence of a clear history of risks identified in 9 out of 12 cases; timely actions through the process in 8 out of 12 cases; and good multi-agency engagement in 8 out of 12 cases.

6 out of 12 cases demonstrated creative work by the Social Worker and tenacity over time working with the parents. There was evidence of safeguarding referrals by Midwives linked to Signs of Safety to help generate maternity safeguarding plans; 7 out of 12 cases were discussed at monthly GP Multi-Disciplinary Team meetings, with risks to the unborn demonstrated clearly in 11 of 12 cases; there was good liaison across Health services by Leicestershire Partnership NHS Trust in 6 of 12 cases. The National Probation Service (NPS) and Domestic Abuse agencies participated in the audit.

## 05 Learning Points

- When working with parent/s who have a learning disability or learning difficulty and/or mental health needs, there should be an assessment of learning needs at an early stage of the referral to ensure understanding of information, including any diagnosis, and to assess parenting capacity. Services should adapt their work to increase understanding for these parents to enable them to demonstrate change.
- Culture, ethnicity, race, and diversity were not reflected in all assessments and records. There needs to be a better understanding and reflection of cultural and diversity needs.
- Cross agency presence at conferences and key meetings needs to be strengthened. GPs need to be given sufficient time to contribute to conferences. It is important to recognise that no single health practitioner represents all of health.
- There needs to be improved sharing of information across Health agencies, including around fathers and male carers/partners and the detail of the family networks.
- Practitioners need to consider services to parents after their baby is removed, as they may need advice on contraception and practical support, and demonstrate a trauma-informed approach.

## 06 Reviewing Practice

- Have you considered and recorded the voice and lived experience of the un/born child and any siblings?
- Have you engaged with fathers/partners/carers/families/support networks and recorded this?
- Have you kept comprehensive chronologies and genograms to understand family networks and relationships? Have local resources been used to support assessments, e.g. Neglect Toolkit?
- Have you reflected on culture, race, ethnicity, acting in a culturally competent way?
- Have you sought management oversight and supervision regarding complex cases?
- Have you given key messages around ICON/Safer Sleeping, including to fathers/partners?

## 07 Resources to support practice

- Pre-Birth and Post Birth Planning procedure and flowchart (under Safeguarding Practice Guidance)
- Training video on Pre-Birth procedure
- Children of Parents with Learning Disabilities procedure
- Children of Parents with Mental Health Problems procedure

# 7-Minute Briefing – Multi-agency working around children under Local Authority care

Safeguarding Children Partnership LEICESTERSHIRE & RUTLAND

Leicester Safeguarding Children Partnership Board WORKING TOGETHER TO KEEP CHILDREN SAFE

## 01 Purpose of this Briefing

It is the responsibility of all practitioners to ensure that children cared for by the Local Authority are safeguarded, listened to and their welfare is promoted. This briefing contains local and national learning.

## 02 Impact of Language

The NSPCC highlight why practitioners should avoid the acronym 'LAC', meaning Looked After Child, when talking about children in care:

- Using the acronym 'LAC' to describe children is depersonalising.
- Labels play an important part in 'othering' children in care, positioning them as different from non-care experienced children. They can exacerbate low self-esteem and make children feel stigmatised.
- When children feel ignored and not listened to this creates a barrier to disclosure.
- Professionals need to challenge the use of such language and help children find their voice.

## 03 Trauma-Informed Practice and Professional Curiosity

Children under Local Authority care, including those residing in placements, may have experienced accumulated harm over their childhood which should lead to a trauma-informed approach. Where a child has been the subject of abuse or neglect, care plans and assessments should analyse what this might mean for future development and wellbeing.

It is important to build a strong professional relationship with the child and provide opportunities to talk about past and current experiences. At times when this fails to create stability for a child in care, professional curiosity about current harm will strengthen the understanding of day-to-day life for the child and provide a wider perspective of their lived experience. Practitioners need to consider if current experiences are contributing to presenting behaviours and be prepared to "think the unthinkable".

## 04 Multi-agency working

The Local Authority always shares Parental Responsibility with those birth parents holding Parental Responsibility where a Care Order (Section 31) is in place. Under Section 20, the Local Authority does not share Parental Responsibility, but they can make some decisions that are delegated. It is essential that, although Children's Social Care may hold Parental Responsibility and have decision making powers, decisions are made in the context of multi-agency working. When there is a disagreement, for example, about medical treatment, direct contact should be expected between Children's Social Care and the relevant Health practitioner and, where possible, exploration with a parent. The aim is a well-informed and agreed approach which balances the views of the parent, including the birth parent and corporate parent (Local Authority); the child, where age appropriate; and Health practitioner. Using existing escalation processes will aid problem solving when resolution is not easy to achieve.

## 05 Multi-agency working across geographical boundaries

If a child under Local Authority care is placed outside the geographical boundaries of their home area:

- The home Local Authority has a statutory responsibility to notify agencies, including Children's Social Care and Health in the receiving/host area, of the move.
- The Independent Reviewing Officer (IRO) is required to be informed of a change of placement, including out of area, and a Review of Arrangements must be held.
- If a child with complex health needs and/or disabilities moves placement, there should be careful planning across agencies to ensure health needs, including equipment and medication, are met. This must be part of the change of placement planning process and, where necessary, a multi-agency planning meeting convened and arrangements confirmed in the statutory review. If there is concern that, based on gaps in provision, the child may be at risk of significant harm, there should be consideration of holding a Strategy Discussion.
- Any child protection concerns which arise are the responsibility of the Local Authority in whose area the child is found (i.e., the physical location where the child suffers, or is identified to be at risk of harm or neglect) and this Local Authority should convene a Strategy Discussion and ensure that they invite the home Local Authority to this meeting.
- If an allegation is made about a person who is working with a child, the responsibility for action lies with the Local Authority Designated Officer (LADO) where the alleged perpetrator holds their substantive post. The home Local Authority must be involved and kept up to date about any process.

## 06 Reviewing Practice

- Do you have a good understanding of the child's / family's history and the child's day-to-day life / lived experience? Is there a focus on evidence, rather than a perceived stability and absence of risk?
- Has the child been involved and kept up to date about their care planning? Have they been given the opportunity to voice their views, including to people outside of a placement? Have they been given information regarding advocacy support that they can access?
- Has there been appropriate multi-agency information sharing between agencies who share responsibility for meeting the child's needs (e.g., Local Authority, Health and Education [the School and Virtual School]), including across geographical boundaries, where required?

## 07 Resources to support practice

"Children Living Away from Home (including Children and Families living in Temporary Accommodation and Private Fostering)" procedure

"Children and families moving across local authority boundaries" procedure

Information sharing around children under Local Authority care – see LLR Local Resources section of the procedures

Building Confidence in Practice Resource Packs: Professional Curiosity for practitioners and supervisors and managers

Voice of the Child – Was Not Heard video

# 7-Minute Briefing – Working with families where there has been parental separation



## 01 Purpose of this Briefing

An understanding of all the significant relationships in a child's life is beneficial. Where parents have separated, the focus should not solely be on the main carer / with who the child resides. When considering the child's needs in the context of parental separation where there has been domestic abuse (including alleged), practitioners need to be aware that there may be ongoing risk and that this may elevate around separation. This briefing contains national and local learning.

## 02 Engagement with parents post separation

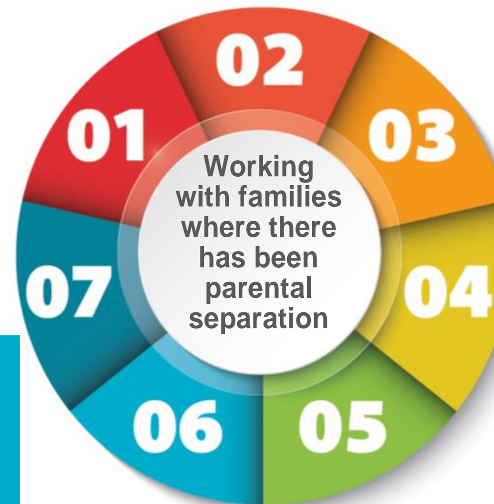
Post separation, unless not appropriate due to domestic abuse / safety concerns, agencies should try to engage with both parents:

- To establish a coherent picture of what the child's life is like
- To triangulate information – e.g., to understand the details of the parents' backgrounds and to explore the impact that the histories of those involved in a child's life may have on the child's experiences
- To ensure there is not an overreliance on parental self-report
- To ensure parents receive consistent messages
- To offer support following custody decisions / significant life changes for the child and parents.

## 03 Hidden Men

The Child Safeguarding Practice Review Panel published their national review entitled "The Myth of Invisible Men" in September 2021. It is important that fathers/male carers are visible to professionals, otherwise there will be limited opportunities to understand their parental role. They need to be 'visible' in records too; practitioners should document more than their attendance. The same level of curiosity and enquiry should be applied to understanding men's lives / experiences as it is to that of women.

Practitioners should consider any potential risk to children from fathers, any new partners of parents, or other adults with close and regular contact with the family, regardless of sex, gender, or sexuality.




## 04 Domestic abuse and understanding escalation of risk post parental separation

Women's Aid highlights parental separation is often mistaken as equating to an end of the abuse and a reduction in risk. In fact, risk can continue or increase after separation and it should not automatically be interpreted as a protective factor. The dynamics of domestic abuse are often based on the perpetrator maintaining power and control over their partner. Challenges to that power and control, for example, separation may increase the likelihood of escalating abuse or homicide.

It is not just about the risk of physical abuse. Practitioners need to respond to possible harassment and stalking type behaviours post parental separation.

## 05 Child contact in the context of domestic abuse and parental separation

When looking at child contact in the context of domestic abuse (including alleged abuse) and parental separation, professionals should consider:

- The motivation of the parent in seeking / maintaining contact with the child – is it a desire to promote the child's best interests or as a means of continuing intimidation, harassment or violence / abuse to the other parent?
- The child's views about contact and whether they have any worries about contact taking place
- In any assessment, the contribution of the wider family network connected to both parents
- The role of each parent in the care and welfare of the child. Remain curious and alert to the risks they may pose, but also any protective factors they may contribute that would be revealed through undertaking a further assessment to establish whether children are safe once adults have separated.

## 06 Reviewing Practice

- Have you taken a child-centred and trauma-informed approach, with a focus on the lived experience of the child?
- Have you considered changing relationships and dynamics in a household, for example, with the introduction of new partners, and understood what this might mean for the child?
- Have the child's views informed analysis and assessment so that intervention is appropriate to address key concerns and needs? If concerns are escalating, ensure safeguarding action is taken.
- Where domestic abuse has been a factor, have you considered the child's experiences and the impact of domestic abuse on their safety, wellbeing and development?
- Has information been recorded, triangulated and shared appropriately? Have invitations to strategy discussions/meetings / child protection conferences / core groups been sent to all relevant agencies, including, where relevant, with domestic abuse services, CAFCASS?

## 07 Resources to support practice

- Domestic abuse procedure: understanding escalation of risk and risk post parental separation
- Practice Principles – Engaging Fathers and Male Carers in Effective Practice
- Resource Pack: "Invisible"/"Hidden"/"Unseen" Men: Engaging fathers and male carers in effective practice

# 7-Minute Briefing – Consenting sexual relationships

Safeguarding Children Partnership LEICESTERSHIRE & RUTLAND

Leicester Safeguarding Children Partnership Board WORKING TOGETHER TO KEEP CHILDREN SAFE

## 01 Purpose of this Briefing

This briefing considers local and national learning regarding the issue of consent in relation to children under 16 who are known to be / considering being sexually active and how this may relate to exploitation.

## 02 The Age of Consent

The legal age for young people to consent to have sex is 16, whether they are straight, gay or bisexual.

Many young people will develop a healthy and developmentally appropriate interest in sexual relationships whilst they are still children and some will do this before they reach the age of consent. However, a child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity.

## 03 Sexual Offences Act 2003

Children **under the age of 13** are legally deemed incapable of consenting to sexual activity and therefore all incidences of sexual behaviour involving children under 13 should be considered as a potential criminal and child protection matter, with notification to the Police and a referral to Children's Social Care.

If a child is between the **ages of 13 and 16**, the Act recognises that, whilst mutually agreed, non-exploitative sexual activity between teenagers does take place, the age of consent should still remain at 16. This acknowledges that this group is still vulnerable, even when they do not view themselves as such. Discussion with/referral to Children's Social Care would depend on the level of risk/need.

Although sexual activity in itself is no longer an offence **over the age of 16, young people under the age of 18** are still offered protection under the Children Act 1989. Consideration still needs to be given to issues of sexual abuse, exploitation and abuse of power. Young people over the age of 16 and under the age of 18 are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by the Act.

## 04 The importance of language

If a child under 16 talks about being in a "consenting relationship" or "consenting to sexual activity", the context of the relationship should still be explored to consider risk factors, vulnerability and if there are any power imbalances due to, for example, age and development.

In their "Why Language Matters" series, the NSPCC discusses how the label 'older boyfriend' can mask child sexual exploitation. They note that accepting a child's use of the term or in practitioners using the term without assessing the risk, they may be legitimising an exploitative relationship and minimising the risk of harm to the child. The NSPCC focus on the term 'older boyfriend' but emphasise that adults or young people of any gender can groom or exploit children, and children or young people of any gender can experience child sexual exploitation.

## 05 Child protection concerns

Where practitioners are working with a child or young person and they are aware of sexual activity with an adult, they need to refer to the Sexual Abuse procedure and not be distracted by discussion around whether the child appears to have consented. Where there are concerns about sexual abuse or exploitation, a referral should be made to Children's Social Care. Where the situation is an emergency, the Police should be contacted immediately. Consideration will be given to the need for an assessment and a Strategy Discussion/Meeting, which can provide an essential opportunity to share information and evaluate risk. The Local Authority holding responsibility for a subject child must be visible and able to contribute to the meeting so that historical information can assist in understanding risk. This should include any relevant health history. An indication of contextual risk should lead to an action for consultation with the Vulnerability Hub to consider any necessary support to the child.

## 06 Reviewing Practice

- Are you recording the voice of the child and curious about the language/labels they use about relationships?
- Have you made it clear to a child that absolute confidentiality cannot be guaranteed, and that there will be some circumstances where they can only be safeguarded by sharing information?
- Wherever safe to do so, have you encouraged the child to share information with their parents/carers? Have you considered the Fraser Guidelines?
- Where a child has/is planning to engage in sexual activity have you considered health, education, support and/or protection needs? With a child under 16 "consenting" to sexual activity, have you taken account of all relevant contextual information from agencies that know the child well, and the individual circumstances of the incident including power imbalance? Have you recorded all discussions, giving reasons for action taken and who was spoken to?

## 07 Resources to support practice

Working with Sexually Active Children and Young People under the Age of 18 procedure and flowchart

Child Exploitation, CSE and Assessment of Risk Outside the Home (Contextual Safeguarding) procedure

# 7-Minute Briefing – Young people who self-harm and/or take their own life

Safeguarding Children Partnership LEICESTERSHIRE & RUTLAND

## 01 Purpose of this Briefing

To present the learning from a local Rapid Review that analysed the multi-agency planning around a White British child who sadly ended her own life at the age of 12.

To make agencies aware of how legal proceedings work for children living in their wider family including when no court order is made, and how support is co-ordinated to families in these circumstances using multi-agency procedures.

To help agencies to feel confident to escalate worries where the appropriate multi-agency planning frameworks are not in place or worries emerge that need a co-ordinated response to children & young people with these vulnerabilities.

## 02 Background

The child was known to Children's Social Care (CSC) throughout most of her life, linked to parental domestic violence, parental substance misuse and parental mental health difficulties. She was subject to multi-agency plans in 3 separate periods between 2015 and 2022, and subsequently she and her siblings went to live with a grandparent under a Section 20 arrangement (Children Act 1989), and a Special Guardianship Order (SGO) was granted by the Family Court in late 2022.

Her school attendance became poor (37.5%), with the school supporting the family to remove the barriers to attending school. This included mentoring in school and a School Counsellor. Concerns were raised in autumn 2022 regarding her low mood and reported self-harm. This was in the context of the grandparent observing anxiety and low mood alongside evidence of superficial scratching.

## 03 Risks Identified and Safeguarding Concerns

- Childhood trauma experienced from a very young age which increased vulnerability.
- Grandparent's self-reporting was relied on to seek support from GP. The child was not seen or questioned by the GP.
- Multi-agency planning was not used to coordinate support.

## 04 Findings

- Appropriate multi-agency planning processes were not in place – this hampered coordinated information sharing and opportunities for identifying emerging risks and vulnerabilities early, particularly around the capacity of the extended family carers to feeling confident in addressing the mental health needs of the child. The step down from Child Protection Plan **should always consider Child in Need planning** where there are continuing legal proceedings including when there is no order.
- There were emerging concerns in respect of the child's school attendance, low mood, anxiety behaviours and the struggle of her carers to manage this, but there was no information sharing across agencies to access support or escalation from agencies to prompt expected multi-agency planning processes.
- Agencies did not fully understand the Mental Health support pathways (Triage and Navigation Pathways) criteria for children experiencing self-harm so that specialist support could be coordinated.
- The Special Guardianship Order (SGO) support plan was not updated despite delays in the process to capture any changes that may have occurred leading up to the order being made.

## 05 Key Learning

Understanding the drivers around self-harm – national picture/statistics show one in 12 children self-harm. The most common method is cutting or head-banging, experiencing mental health problems such as depression or anxiety. They may have experienced adverse childhood experiences including being abused or being exposed to difficult parental problems such as domestic abuse, substance misuse and poor mental health.

The child had been subject to Child Protection processes in the past and when these concluded there was no active multi-agency planning put in place despite this being a recommendation as an outcome of the final Review Child Protection Conference. This meant an opportunity for close co-operation between the extended family caring for her and the network of professional agencies did not exist using Child in Need planning. Any concerns of agencies that this process was absent were not escalated with CSC.

The child had been reported as having low mood, anxiety, refusing school, had experienced childhood trauma through the behaviours of her parents. This was known by the school who put in place support, but they were over reliant on a family member reporting that GP appointments had been made when this was not true. Given the emerging concerns, there was little contact with CSC and no escalation of concerns around the need for multi-agency planning to support the child and her family in coordinating responses.

## 06 Reviewing Practice

- Ensure key multi-agency processes are used to deliver consistent oversight, planning, information sharing and access to support services.
- Where agencies involved with a child can see the need for a multi-agency process, then confidently escalate the concern when there are barriers or delay in them being put in place.
- Monitor and review a child's attendance and link it to any vulnerabilities and trauma-informed practice that may increase risk and need for support/intervention.
- Professionals should be aware of the triage and navigation pathways and associated criteria to access mental health services and seek support to access specialist services in response to self-harm and suicidal ideation.

## 07 Raising awareness and implementing learning

- Use this 7-Minute Briefing in a team meeting to raise awareness and explore the learning, with particular emphasis on the processes for multi-agency planning at the conclusion of Child Protection Plans and the need to escalate concerns when this does not happen
- To make staff aware of the Self-Harm and Suicidal Behaviour procedure (updated September 2024) and the LLR Practice Guidance: Supporting Children and Young People who Self-Harm and/or have Suicidal Thoughts (accessible via the procedure)
- Resolving Practitioner Disagreements and Escalation of Concerns
- CAMHS referral process, service and criteria

Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE

# 7-Minute Briefing: Supporting Disclosure of Child Sexual Abuse (2024)

## 01. Purpose of this Briefing

The purpose of this briefing is to equip local practitioners to enable them to support children and young people in recognising and disclosing sexual abuse.

This briefing provides practitioners with local and national child sexual abuse research, information, and practical resources to support with this important and often difficult area of work.

## 02. Background

Leicester's Safeguarding Children Partnership carried out and published a local child safeguarding practice review (LCSPR) which recommended a local initiative to ensure that children feel supported in recognising and disclosing sexual abuse.

## 03. Barriers to disclosure of child sexual abuse

Cossar J. et al. (2013) 'It takes a lot to build trust' Recognition and Telling: Developing earlier routes to help for children and young people' Office of the Children's Commissioner for England identified five main barriers to disclosing child sexual abuse, in order of their frequency:

1. An emotional barrier, e.g. shame, embarrassment, not being able to face telling, finding it hard to find/say the words;
2. Worry about the family knowing, loyalty to family and the impact on family members;
3. Thinking their situation was not problematic enough to disclose to others;
4. Threats from the abuser;
5. Fear of not being believed if they were to tell.

## 04. Barriers to disclosure of child sexual abuse

Ilnock, D. and Miller, P. (2013) No one noticed, no one heard: a study of disclosures of childhood abuse. London: NSPCC describes the childhood experiences of abuse of 60 young men and women and how they disclosed this abuse and sought help. Over 80% of the children in the study had tried to tell someone about the abuse. Disclosure – especially at the time of abuse – is rarely a straightforward process of a child or young person saying they have been abused. Many disclosures were either not recognised or understood, or they were dismissed, played down or ignored; this meant that no action was taken to protect or support the child or young person.

## 05. Supporting disclosure of child sexual abuse

•Be prepared to think the unthinkable: recognise that foster carers or kinship carers might sexually abuse children. Beliefs that placements are settled and perceptions that carers are capable can provide false reassurance that children are safe and well cared for.

•Make time to speak to children and young people alone and outside of the home / placement where they can talk freely and where practitioners can build trusting relationships and understand a child's lived experience.

•Be aware that if several agencies / practitioners are involved it may give false reassurance children and young people will talk to or disclose concerns to other people.

• Understand that an abusive situation is not always recognised by the child or young person as abuse. Ask and listen to what they are saying including what they are trying to convey through what they say, what they do not say, their behaviour, and their body language.

•Where it is required, use an interpreter.

## 06 Supporting disclosure of child sexual abuse

•Some children and young people find it easier to discuss sensitive topics if they can avoid eye contact, e.g. doing activities alongside the adult, in the car, doing the washing up, or going for a walk.
•Face to face disclosure can be difficult – an alternative strategy is to find ways for children and young people to put their concerns in writing to be read when they are not present.
•Research has found that teachers and school-based support are particularly important as people to disclose to (Cossar J. et al. 2013)
•Do not rely unduly on children disclosing verbally.
•Young people may be encouraged by a sensitive but persistent response from a practitioner conveying care.
•Explain to children and young people how their concerns are likely to be handled, and the outcome, and include them in discussions about when and how to pass on information.

## 07. Next steps

See the next page to read what children and young people have to say.

Go to the last page of this briefing for an overview of free training and resources, including local multi-agency training, local and national resources to support you in practice, and local multi-agency policies and procedures for use in practice.

Read the LCSPR in full, alongside other published reviews and learning briefings on the Safeguarding Children Partnership website.

Explore the published research linked to in this briefing and look out for the upcoming Child Safeguarding Practice Review Panel publication national review into child sexual abuse within the family environment.

# WHAT CHILDREN AND YOUNG PEOPLE SAY

Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE

"If we tell you, don't tell our abusers"

Local Child Sexual Abuse Survivor

"Listening to the young people you work with isn't always about the words we say. My actions spoke louder than my words"

Local Child Sexual Abuse Survivor

"I have to like you first to trust you and I have to trust you to talk to you"

Local Child Sexual Abuse Survivor

"One worker listened to me and when they listened without judgement and with compassion a difference was made. They believed me and they acted upon what I told them"

Local Child Sexual Abuse Survivor

"I never told anyone about this as I didn't think anything was wrong, but I've come to realise now"

Cossar J. et al. (2013, p.42)

"I should be able to defend myself. But I can't I just get so scared. I should have more control over my body so they can't force me into being aroused, but I don't know how to stop it"

Cossar J. et al. (2013, p.38)

# FREE TRAINING & RESOURCES AVAILABLE TO YOU

Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE

## NATIONAL RESOURCES

Child Sexual Abuse Response Pathway: An interactive online resource to guide professionals through how they can protect and support children and their families when there are concerns of sexual abuse.

This step-by-step resource is centred on children's needs, how they are feeling and what they hope will happen.

## NATIONAL RESOURCES

Centre of expertise on child sexual abuse which includes:

Resources to help education professionals to identify and respond when they have concerns about child sexual abuse or behaviour

Signs and indicators template

Communicating with children

## LOCAL RESOURCES

'Was Not Heard' a locally co-produced short film advocating the right of children to be heard and the duty of those working with them to act.

How will you hear me? A collection of local short films written by young people exploring their experiences and how they felt they were treated and listened to. The final scripts are performed by young actors.

## LOCAL TRAINING

LLR Safeguarding Children Partnerships Multi-Agency Training

Look out for training such as 'Following the Breadcrumbs: Understanding and working with disclosures of child sexual abuse' online training delivered by survivors from REIGN, designed for any adult with a role to play in protecting children.

## LOCAL TRAINING

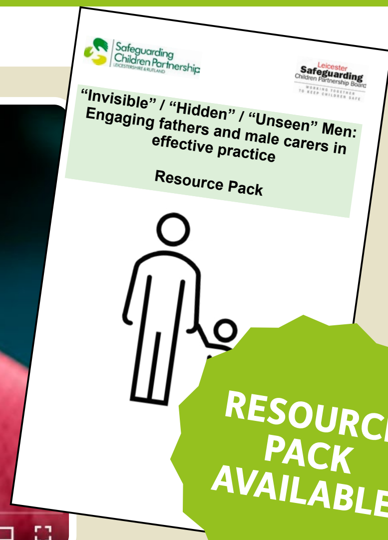
Watch the 22 minute recording of Safeguarding Matters Live held in July 2024 with a focus on Child Sexual Abuse from 51:16 minutes in through to 1:13:25 which focuses on case studies, local and national data, and local and national learning from reviews.

7-Minute Briefing on Child Sexual Abuse in the family environment which includes national and local learning and resources.

## LOCAL MULTI-AGENCY POLICIES & PROCEDURES

Leicester, Leicestershire and Rutland multi-agency Sexual Abuse procedure which includes a flowchart for referring to the East Midlands Children and Young People Sexual Assault Service.

Child Sexual Abuse in the Family Environment




# "Invisible"/"Hidden"/"Unseen" Men:

## Engaging fathers and male carers in effective practice

**In 2021, the Child Safeguarding Practice Review Panel published their third national review entitled '"The Myth of Invisible Men": Safeguarding children under 1 from non-accidental injury caused by male carers'.**

From universal to specialist services, national and local learning has told us that our knowledge of and engagement with men needs to be improved. They are often missing from routine engagement with practitioners, not always "visible" in recording, with detailed pictures of fathers/male caregivers missing from assessments. The same level of curiosity and enquiry should be applied to understanding men's lives/experiences as it is to that of women.

The Leicester and Leicestershire & Rutland Safeguarding Children Partnerships have carried out a lot of work on this theme. They have collated links to key national and local resources in a Resource Pack, which is available here.

# National Child Safeguarding Practice Review Panel

**Responsibility for how a system learns lessons from serious child safeguarding incidents rests at a national level with the Child Safeguarding Practice Review Panel and at a local level with the three Safeguarding Partners (Integrated Care Boards, Police and Local Authorities) and other partner agencies, which form Safeguarding Children Partnerships.**

The Child Safeguarding Practice Review Panel works with the Department for Education. They publish a range of publications, including national reviews and Panel briefings.

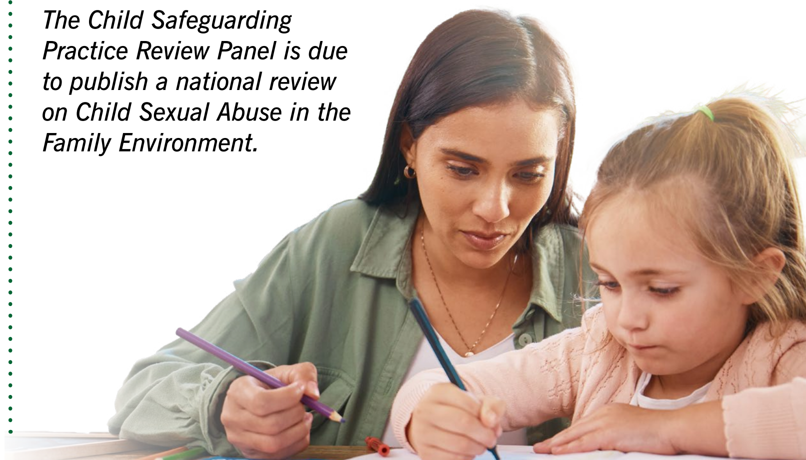
Their most recent Panel Briefing, published in May 2024, focuses on "Safeguarding children in Elective Home Education". A webinar on this briefing, provided by the Child Safeguarding Practice Review Panel, is available on their YouTube channel here.

Locally, in September 2024, the Leicester and Leicestershire & Rutland Safeguarding Children Partnerships updated their multi-agency procedure manual to include a new chapter on "Elective Home Education: An Approach to Safeguarding for LLR".

A presentation on Electively Home Educated Children was delivered at Safeguarding Matters Live in July 2024. A video of the event is available on the LLR SCP YouTube channel here.

If you want to listen specifically to this presentation, please scroll forward to 1:20:40.

*The Child Safeguarding Practice Review Panel is due to publish a national review on Child Sexual Abuse in the Family Environment.*



# Impact of parental cannabis use on children

**A rapid review was completed last year where a child died by suicide. Social Care had been involved in their life for several years with intermittent concerns regarding their mother dealing drugs from home and habitually smoking cannabis around her child. A recommendation from that review noted that:** ***'The Safeguarding Children Partnership recognised that it does not know enough about secondary cannabis smoke and the impact of passive cannabis exposure.'*** **This article is as a response to the above and an endeavour to learn more about the impact of secondary cannabis smoke/passive cannabis exposure.**

Firstly, we have to think about what the known risks are from smoking cannabis. It can make some existing mental health symptoms worse and has been linked with the possible development of mental health issues. The risk factors include an underlying vulnerability to mental health issues and this is linked to family history, heavy cannabis use from a young age over a long period of time, or use of high potency cannabis (nhs inform).

People using cannabis every day over a prolonged period may develop a tolerance of the effects. They may need more to get the desired effects or may experience dependency.

**The most commonly reported symptoms are:**

- difficulty sleeping
- vivid dreams or nightmares
- low mood and mood swings
- anxiety, paranoia, and hallucinations
- difficulty concentrating
- impaired memory – not being able to remember or learn new information
- irritability
- cravings

Inhaling any substance into your lungs can cause irritation to the delicate tissue and is linked to physical health risks such as wheezing, coughing, increased risk of lung cancer, increased heart rate affecting blood pressure which in turn can lead to heart disease. This includes tobacco, cannabis and vaping products (nhs inform).

However, these are known symptoms if people are using cannabis directly. The review above was from a child living in an environment where cannabis was regularly smoked and was a normalised behaviour.

In gathering information for this article, it has become clear that there is little information or research in this area, and what has been done is mostly from the USA. What we do know is that there are known risks of second-hand exposure to tobacco smoke, including risks to the heart and lungs, and this raises questions about whether second-hand exposure to cannabis smoke causes similar health risks. Second-hand cannabis smoke contains many of the same toxic and cancer-causing chemicals found in tobacco smoke and some in higher amounts.

Second-hand cannabis smoke also contains tetrahydrocannabinol (THC), the compound responsible for most of cannabis's psychoactive effects or the "high". THC can be passed to infants and children through second-hand smoke, and people exposed to second-hand cannabis smoke can experience psychoactive effects, such as feeling high. A high that an otherwise sober person experiences when they are near someone under the influence of recreational drugs is known as a 'contact high'. For a 'contact high' to be possible, a person would need to be in close contact with highly concentrated cannabis smoke for an extended period in a poorly ventilated area.

Therefore, it is not surprising that studies have found strong associations between reports of having someone in the home who uses cannabis, such as a parent, relative or carer, and the child having detectable levels of THC. Children exposed to THC are potentially at risk for negative health effects. More research is needed to understand how second-hand cannabis exposure may affect children.

Other research shows that cannabis use during adolescence can impact the developing teenage brain and cause problems with attention, motivation, and memory.

It is clear that more research about the effects of cannabis second-hand smoke is still required. Concerns are raised because of the increase in the potency of cannabis through increased concentration of THC. Moreover, cannabis is the most widely produced and illicitly consumed drug globally and in England it appears to be widely accepted as a less harmful drug and its

use can be normalised in communities and homes. This can be through arguments where people cite that alcohol is a more dangerous drug, and that because it is illegal cannabis is seen as more harmful. Both alcohol and cannabis are harmful and have immediate and long-term impacts.

Another local Review found that there had been use of cannabis during pregnancy. For this we know that there are risks to the unborn baby. Again, it is the THC that is harmful as this is the hallucinatory element of cannabis. If a pregnant mother is using cannabis, it can cross the placenta exposing the foetus to the chemicals it contains. It is associated with a reduction in oxygen and nutrition via the placenta, growth restriction, impacts on the nervous system development, preterm labour and low birth weight. It is linked to stunted growth, anxiety and depression, reduced attention and executive functioning skills, poorer academic achievement, and more behavioural problems in later life due to the impact that THC has on the baby's developing brain. This is because cannabis smoke during pregnancy can produce three times as much tar and five times as much carbon monoxide than smoking tobacco. If smoked with tobacco, the impact increases.

Locally Turning Point provide our drug and alcohol services and they have many resources on substance misuse, including cannabis, on parenting, child development and during pregnancy. This information is shared with their clients during sessions where appropriate. Where a child is living in an environment where cannabis use is normalised and the parent is also dealing from the house, there could be an impact not only from secondary inhalation but also on how the child is parented and again there is a work pack and resources used by Turning Point to support their clients who are parents.

Turning Point work with adults and young people. They are a great resource and information for Leicester can be found here: Leicester | Turning Point (turning-point.co.uk) and for Leicestershire and Rutland here: Leicestershire & Rutland | Turning Point (turning-point.co.uk)

In addition, there are specialist midwives for substance misuse who deliver tailored maternity care and safeguarding for women where they are pregnant and using substances. A session delivered by Turning Point and the Specialist Midwives on the Impact of Substance Use During Pregnancy is available here: Impact of Substance Use During Pregnancy Turning Point - YouTube

**Resources (including those highlighted by Turning Point):**

- The impact of parental substance use on child development: Frontline Briefing (Research in Practice, 2020) (free if you have a membership)
- Parental Substance Use: Supporting School-Aged Children: A BASW Practice Guide (British Association of Social Workers, 2022)
- Positive Parenting: NSPCC Need-to-Know Guide (NSPCC, 2016)
- 7-Minute Briefing on Impact of parental substance use on children (Leicester and Leicestershire & Rutland Safeguarding Children Partnerships, 2024)

**Sources for article (all accessed 17/09/2024 and 03/10/2024):**


1. Cannabis | Weed | Effects of Cannabis | FRANK talktofrank.com
2. Scottish health information you can trust | NHS inform
3. Cannabis and Secondhand Smoke | Cannabis and Public Health | CDC www.cdc.gov
4. Secondhand marijuana smoke: Side effects and risks medicalnewstoday.com
5. Non-Smoker Exposure to Secondhand Cannabis Smoke. I. Urine Screening and Confirmation Results - PMC nih.gov


# **NSPCC** – National Case Review Collection and Learning from Case Review Briefings

**The NSPCC works to ensure that learning from case reviews can be accessed and shared at a local, regional and national level.**

It provides a National Case Review Collection which is a searchable repository of published case reviews.

It also publishes learning from case review thematic briefings.

You can sign up for NSPCC safeguarding and child protection newsletters via their website here.

# Leicester and Leicestershire & Rutland Safeguarding Children Partnerships Procedures Manual updates

The Leicester and Leicestershire & Rutland Safeguarding Children Partnerships provide multi-agency procedures. These are updated in line with learning from local reviews and audits and national learning.

**In September 2024, the following amendments were made to the manual:**

## Updated Chapters

| Chapter Name | Details |
|---|---|
| Assessment | This chapter has been updated in line with the revised Working Together to Safeguard Children. |
| Information Sharing | This chapter has been revised in line with updated government guidance. |
| Good Practice Supporting the Voice of the Child | This chapter has been updated in line with the revised Working Together to Safeguard Children. |
| Child Criminal Exploitation | Minor amendments have been made to definitions in line with Working Together to Safeguard Children. |
| Child Exploitation, CSE and Assessment of Risk Outside the Home (Contextual Safeguarding) | This chapter has been updated. |
| Dangerous Dogs and Safeguarding Children | This chapter has been refreshed. |
| Domestic Abuse | A new Section 7, Non-fatal Strangulation has been added. |
| Female Genital Mutilation and Other Harmful Practices | Section 7, NHS Data Sharing has been refreshed and updated. |
| Online Safety | This chapter has been updated in line with the Online Safety Act 2023. |
| Self-Harm and Suicidal Behaviour | This chapter has been updated throughout. Section 3, Risks and Section 4, Protective and Supportive Action must be reread. |
| Working with Sexually Active Children and Young People Under the Age of 18 | This chapter has been reviewed and updated throughout. It has a new name (previously “Underage Sexual Activity”) and a flowchart has been added. |
| Guidance for Safe Recruitment, Selection and Retention for Staff and Volunteers | A link has been added to Education Supply Chains – A Better Hiring Toolkit. |

## New Chapters and Features

| Chapter Name | Details |
|---|---|
| Children from Abroad, including Victims of Modern Slavery, Trafficking and Exploitation | This new chapter has been added to the manual. |
| Elective Home Education | This chapter has been added to the manual. |
| Safeguarding Children with a Social Worker, Children in Care and Care Experienced Children at School | This chapter has been added to the manual. |

If you want to sign up for alerts regarding the Safeguarding Children Partnerships’ procedures, you can register for updates here.

# What can the Safeguarding Children Partnerships of Leicester, and Leicestershire & Rutland do for you?

## Policies and Procedures

The Leicester, Leicestershire and Rutland Safeguarding Children Partnerships have a Procedures Manual which has guidance, procedures, and resources for all of those who work in the children's multi-agency workforce.

It has:

1) Core Procedures
2) Safeguarding Practice Guidance
3) Safeguarding Partnership Arrangements (Roles & Responsibilities)
4) Appendices and Protocols

*Not sure what to do?*

*Need some advice/support?*

Please look at the procedures manual and search the topic!

Leicester and the Leicestershire and Rutland Safeguarding Children Partnerships Procedures Manual (proceduresonline.com)

## Training

The Leicester, Leicestershire & Rutland Safeguarding Children Partnerships provide:

- A Multi-Agency Training Programme, advertised via X (Twitter), which offers free of charge, high quality training, with a core programme focusing on basic safeguarding / business as usual training, supplemented by commissioned training on key safeguarding themes and specific types of abuse/neglect, as well as large scale events.
- A Competency Framework to support individuals and organisations to undertake their safeguarding roles and responsibilities in a confident and competent manner.
- A Trainers Network that offers regular meetups between trainers to share knowledge, skills and to help develop the delivery of safeguarding children training. If you would like to join the Network, please email lscptraining@leicester.gov.uk.

## Learning & Development Resources

- YouTube Channel
  provides a bank of safeguarding videos that capture presentations from multi-agency training events and other resources that can be utilised by partners for learning and development – for example, in single agency training and supervision.
- 7-Minute Briefings
  designed to convey key messages from national and local reviews and audits and encourage managers and workers to reflect on their practice.
- Building Confidence in Practice Resources
  focus on often complex issues that arise for practitioners when they are working with people, whether they are children or adults. They can be used in team meetings or as part of a group/individual supervision.
- Leicestershire & Rutland Practice Points – Learning from Safeguarding Children Partnership Reviews and Audits

## Safeguarding Matters

- Print Newsletter
- Live Events
- Digest emails

with a focus on disseminating learning from reviews and audits, promoting procedural updates and disseminating local and national safeguarding information. If you would like to be added to the mailing lists, please contact LRSPBO@leics.gov.uk OR LSCPB@leicester.gov.uk

Safeguarding Children Partnership
LEICESTERSHIRE & RUTLAND

Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE