A Local Child Safeguarding Practice Review

Molly

Report Author

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1. Introduction

Reason for the Local Child Safeguarding Practice Review (LCSPR[1])

1.1 This review is about Molly, one of a group of children nationally who have had significantly traumatic, chaotic, and abusive early lives where the response was not timely leaving the potential for those early experiences to cast a long shadow of harm, despite being placed with loving, caring, and permanent families. It has taken many years for there to be recognition of the importance of the right support being provided to those children and families at the earliest stages, and we are still learning what that support should look like.

1.2 The absence of this skilled and sensitive support leaves children who have not been taught to form attachments and relationships, to know how to regulate their emotions, how to adapt to the trials and tribulations of life and to know who to trust to help them. These children are left to communicate their distress through sadness, anger, violence, self-harm and suicidal ideation, sexual confusion, and a need to control where no control has previously been possible. This can take its toll on those loving and caring parents who take on the task of reparenting these children and who are often left themselves experiencing secondary trauma when coping with this distress. With the passage of time, particularly into adolescence, it is possible that professionals lose sight of the trauma and start to see the child's distress as an internal characteristic which needs treatment or fixing; we can lose sight of 'what has happened to you' and move into 'what is wrong with you'. This is the context for the first part of this review.

1.3 The second part of the review is about how early unaddressed trauma and distress can lead to family relationships breaking down, and children needing alternative and safe care in new families and residential care. This requires careful thought and planning, in the context of a national lack of specialist provision.

1.4 The third part focusses on how we can keep children living in residential care safe from sexual harm. There is growing national concern about levels of harmful sexual behaviours affecting on children and young people; this behaviour ranges from sexist and homophobic name calling and comments, spreading rumours about sexual activity, sexually abusing online, sharing of indecent images of children, inappropriate and unwanted sexual touching, sexual harassment, sexual assault and rape. Schools have had to move on from wondering if sexual harm happens in their school, to accepting that it does happen, and that proactive action is necessary regarding prevention, appropriate action when children have been harmed or have harmed others, safety planning and support. The child at the heart of this review made an

[1] A Child Safeguarding Practice Review (previously known as a Serious Case Review (SCR)) is undertaken when a child dies or has been seriously harmed and there is cause for concern as to the way organisations worked together. The purpose of a child safeguarding practice review is for agencies and individuals to learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

allegation of several incidents of sexual harm by other children and this will be discussed further in the analysis section at the ned of this report.

About Molly and her parents: they are all White/British

1.5 Molly moved to live with her parents when she was four and a half and her history was known to them. They reported that they had not been provided with appropriate support and the parents talked of these early years as being difficult for Molly and for them. They accessed private counselling, which was helpful, but they felt did not address any of their needs.

1.6 This review reflects on Molly and her parent's journey through services in Stockport over a three-and-a-half-year period from when Molly was nine. Molly had a lot of contact with professionals, and they have described her as a friendly young person, who has a kind heart and a dry and sarcastic sense of humour. She is good at singing and dancing and her parents supported her to attend dance classes. Molly did well at school academically and had an ambition to go to university, however over time she started to struggle in school. Molly enjoys going for walks in the countryside with her parents, the family dogs, and friends. Molly loves social media, specifically Tik Tok and regularly learns new dances. She is very good at drawing and uses this to demonstrate her feelings. Professionals were aware that Molly experienced significant trauma and that this was manifest in her ability to form and keep friendships, regulate her emotions, and particularly talk about her feelings.

Process of the LCSPR

1.7 This review has been led by Jane Wiffin[2], an independent person with no practice links to Stockport. The methodology used was the significant incident learning process (SILP[3]). This process is consistent with the requirements laid out with Working Together for the conduct of an LCSPR.

1.8 The review process was overseen by a panel of senior managers/safeguarding professionals representing all the agencies who had contact with Molly and her parents. They have acted as critical friend the independent reviewer and helped with local knowledge and analysis of the information and considering key lines of enquiry which form the questions at the end of this report. The independent reviewer would like to thank them for their hard work, reflections and responses to the many questions asked in seeking to understand Molly's world.

1.9 Individual agency reports were commissioned, which provided an analysis of the services provided to Molly and her parents and made single agency recommendations.

1.10 The frontline professionals who worked with Molly and her parents were brought together as a group on two occasions. One to reflect on the emerging learning form a review of Molly's circumstances and once to review the draft report. It is not always easy t review your own practice response to a family, but professionals have done this with openness, intelligence, and most of all

[2] Jane Wiffin has a professional background in social work. She has chaired and written many serious case reviews (SCR)/local child safeguarding practice reviews (LCSPR). She also works as a Practice Improvement Advisor for the Centre of Expertise on Child Sexual Abuse.
[3] SILP Reviews – Review Consulting

as a commitment to wanting the best for Molly and other children in her circumstances. The independent reviewer would like to thank them for their time and help.

Family Involvement

Molly

1.11 The Independent reviewer met with Molly to get her views. She is an engaging young person, who is also very shy. She reported that she was not sure what would have made a difference to her or what she would change. Her messages to professionals were:

- Please don't take away my mobile phone- it is how I communicate.
- I like my social worker now. She has my back. That makes a difference.
- I want to know what is happening and for people to make sure I understand this.
- I am living somewhere where I am happy.
- My family matters to me.

The parents

1.12 The Independent reviewer also met with the parents. Their views are woven into the report. They said:

- We needed help when Molly came to live with us, and this did not happen. We know this caused lots of difficulties for us and Molly.
    - The review is seeking reassurance from this local authority[4] that this would not be the case now.
- We reported concerns that Molly was harmed by her second foster carer when Molly was four. We have heard nothing about this.
    - The review is seeking information from this same local authority about what action was taken (see footnote below).
- We love Molly. Please do not use the phrase 'adoption breakdown' it makes us feel that she is no longer part of our family. She will always be part of our family. It also makes us feel like we failed her.
- Please understand that we know Molly's difficulties stem from external factors – the trauma and abuse she experienced- but that does not mean we should not talk about those difficulties and how they can be addressed. We felt that professionals thought we were being negative about her. We were just wanting help for her and for ourselves to help her. This led to an undue focus on positives, without there being a balance. We know Molly's strengths too.
- We needed more support from the trauma induced violence from Molly. It made us scared.
- We want to thank professionals for their support over the last few years.
- We miss Molly and hope she can be safe and return home.

[4] This authority is not named for reasons of anonymity for the family, but a copy of this will be sent to their independent Chair of the Safeguarding Children Partnership.

2. Succinct timeline of Molly's journey through services: 2018 to 2021

Time scales	Professional support	
Molly aged 9		
2018		
January to March	Molly moved to a new primary school.	Full history was shared, and counselling provided to Molly and support to parents.
March to January	Early Help Plan[5]	Parents concerned about Molly's anger, violence at home, self-harm, and suicidal ideation.
	Referral to Adoption support	Adoption support started the process of commissioning a specialist assessment of Molly's therapeutic needs to find the most appropriate therapeutic intervention and organised for the parents to attend a 10-week Child Parent Violence course.
	Referral to Child and Adolescent Mental Health, Services (CAMHS[6])	Initial appointment attended, but parents felt that Molly did not need further support at this time
Molly aged 10.		
January	Adoption support make a referral to Stockport children's social care (SCSC).	Growing concerns about Molly's distress, further violence, and self-harm.
	SCSC start child and family assessment[7].	
March	Child in need plan[8] agreed	The plan agreed. • Help with parenting. • Life story work. • Ongoing support for Molly to help her regulate her emotions, manage her aggressive and angry behaviour and self-harm. • There would also be a package of support provided

[5] Early help, also known as early intervention, is support given to a family when a problem first appears. It can be provided at any stage in a child or young person's life. Statutory guidance highlights the importance of supplying early intervention, rather than waiting until a child or family's situation escalates (Department for Education (DfE), 2018.

[6] CAMHS stands for Child and Adolescent Mental Health Services. This is the name for the NHS services that assess and treat young people with emotional, behavioural, or mental health difficulties.

[7] A Child and Family Assessment addresses the central and most important aspects of the needs of a child / young person, and the ability of his or her parents or care givers to respond appropriately to these needs within the wider family and community context.

[8]

This is a plan that sets out what extra help children's services and other agencies, including health and education, will provide for a child in need and their family. The plan should be drawn up in partnership with the child and their family after a child in need assessment.

[8] An early help plan is an action plan to meet the assessed need of a child, young person and their family.

		by the adoption support agency. • School support would continue. • There would be regular child in need meetings.
May	There were two notifications to the police by the parents about Molly's aggression to parents and self-harming.	A crime was recorded of common assault; the parents would not support a prosecution.
May	Referral to CAMHS by school and paediatrician worried about Molly.	The family attended an initial consultation but were advised of long waiting lists and accessing support via the adoption support team was recommended.
Molly aged 11		
	Child in need plan ends and Team around the Child (TAC[9]) plan in place. School, the Lead Professional[10].	
September	Molly moves to secondary school	Good transition support was provided and ongoing support in school agreed.
September	The specialist assessment of therapeutic need commissioned by the adoption support agency started. It would complete in December.	The conclusion was that Molly had experienced significant developmental trauma in her early years which was impacting on her emotional regulation and self-esteem. This was said to be manifest in anger at home and sensitivity to abandonment and rejection. The parents were described as overwhelmed, exhausted, and so struggling to respond effectively to Molly. The report recommended a three-stage intervention programme starting with addressing Molly's developmental trauma through sensory based work and therapeutic parenting support.
December	Specialist assessment completed.	This was shared with Molly, her parents and school. The

[9] A Team Around the Child (TAC) is for children and families who need extra support from professionals to achieve expected standards of health, education, development or welfare. The TAC is a group of people, including the child, family members and professionals, who will work together to support the child and family.

[10] The Lead Professional (LP) is the person who will keep contact with the child and family, lead TAC meetings and be responsible for coordinating the Child's Plan. The person who acts as LP will be decided through discussion with the child and family.

		commissioning process for DPP and sensory supported started.
2019		
April	The Dyadic Developmental Psychotherapy (DDP[11]) commissioned by Adoption support started.	Quickly agreed that the parents were under a great deal of stress and counselling was needed. This was sought and started in August.
June	Allegation of harmful sexual behaviour[12] by Molly.	Strategy discussion[13] was convened and child and family assessment started. Agreed child in need plan.
June	Molly hospitalised due to self-harm.	CAMHS assessment.
August	Child in need plan in place	• Direct work with Molly by the allocated social worker, focussed on keep safe work and building relationships. • Therapeutic support for the parents would continue through adoption support. • Life story work would be considered. • Short breaks were offered.
Molly aged 12		
November	Further concerns about sexually harmful behaviours	It was proposed that the social worker would undertake an AIMS3 assessment, but Molly denied the concerns making it not possible to undertake the assessment. No other frameworks were considered.
2020		
January	The sensory work[14] proposed in the specialist adoption support assessment started.	This was completed virtually, and it was considered this support was not meeting Molly's needs.
February	The adoption support social worker referred Molly to CAMHS in 2021 because of escalating concerns about	CAMHS completed a risk assessment. A safety plan was put in place and advice about how to help Molly manage her

[11] Dyadic Developmental Psychotherapy (DDP) as a support and intervention for families with adopted or fostered children who had experienced neglect and abuse in their birth families and suffered from significant developmental trauma.

[12] See the analysis section of this report for a description of what is meant by sexually harmful behaviours (HSB)

[13] The purpose of a strategy discussion is to decide whether the threshold has been met for a single or joint agency (police/children's social care) child protection enquiry, and to plan this. They happen when it is believed a child has suffered, or is likely to suffer, serious harm. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[14] Sensory-based interventions address an individual's sensory system in a therapeutic manner to create change and enable adaptation to one's physical environment and have been used with children with behavioural issues and complex trauma histories.

	self-harm, suicidal ideation, and difficult relationships with other children.	emotional dysregulation. It was agreed that CAMHS would provide support to Molly and her parents. This was started.
February	The parents called the police after Molly had physically assaulted one of her parents.	A crime of common assault was recorded, and the parents refused to support a prosecution.
March	Care Planning Meeting[15]. Concerns were the same as they had been for some time with an escalation of self-harm and difficulties at school with peers. There were also worries that Molly was groomed into contact with an older male on social media.	It was agreed that there needed to be additional respite care and intensive support for Molly and her parents at home. The parents were still in therapy.
May	The parents reported a physical assault by Molly to the police.	A crime of common assault was submitted, but the parents would not support a prosecution.
May	The parents asked that Molly come into the care of the local authority.	Molly was placed with the foster carers who had provided short breaks; she would remain until July.
May	Molly was brought to A&E by the parents due to concerns about self-harm.	A full mental health and risk assessment was completed. She was discharged home with follow up from Community CAMHS.
May	Molly sought contact with her birth family.	This was discussed with her, and advice given about how to make these family arrangements safe.
July	Molly moved to a new foster care family placement.	This would last until December.
Moly aged 13		
September/October	Molly was assessed by a child and adolescent psychiatrist from CAMHS. The psychiatrist concluded that Molly was experiencing symptoms of low mood and anxiety, had an attachment disorder and developmental trauma which was causing poor emotional regulation and resulting in self-harm.	The plan was for Molly to see a CAMHS Mental Health Practitioner monthly to discuss strategies about self-harm and risk management.
October	Molly took an overdose and was admitted to hospital. A	Molly was seen by a CAMHS mental health practitioner. It was

[15] Care Planning Meetings are held regularly for the Local Authority can consider the efficacy and direction of the current care plan for a care experienced chip, work on a partnership basis with all professionals involved, family members and the young person.

	friend from school also took an overdose and there were ongoing concerns that the young people were influencing each other.	felt that recent contact with her birth family had been a source of stress. Advice about safety was provided.
December	Molly took another overdose and there were concerns about suicidal ideation. She was admitted to hospital.	Her foster carers said they could no longer manage Molly's needs and she moved to a new foster carer on discharge from hospital. A safety planning meeting was convened, and a Safety Plan developed.
2021		
January	There was a Looked After Review There were concerns that Molly's self-harm had escalated and she was accessing social media sites on self-harm and was encouraging other children to self-harm. Molly continued to be in on-line contact with some members of her birth family.	A safety plan was agreed. Molly asked to move from the foster carers.
February	Molly self-harmed and was admitted to hospital.	She was referred to the CAMHS Rapid Response team (RRT). An initial assessment and support was provided over the next 72 hours.
February	A legal planning meeting was held.	It was agreed that a specialist residential would be looked for.
February	A residential children's home was found with an outstanding Ofsted rating.	A comprehensive placement referral was made outlining all of Molly's needs.
February	The social worker visited and discussed the profiles of the children placed in the home. Molly was the youngest child at 13.	Information about a history of allegations of harmful sexual behaviours concerning one of the residents was not shared.
February 17th	Molly moved to the residential children's home.	It was agreed that the CAMHS home treatment team would provide initial support. There was no permanent education provision in place at this time.
February 18th	There was a conversation between the CAMHS home treatment team and the residential children's home.	This led to a misunderstanding about Molly making false allegations against professionals, needing two members of staff for staff safety, and needing constant supervision. This

		information was not clarified by the children's home.
March 8th	The residential children's home become aware that there were concerns that Molly had been sexually assaulted by a friend (aged 15) of one of the residents (Rik) two days earlier; Jay, aged 16.	The police were called, and Molly was interviewed. The social worker visited.
March 12th	One of the female residents made staff aware that there was a TikTok video of Molly looking pregnant with messages suggesting sexual activity with Rik.	This was discussed with Molly, who denied this was her. She did report that she thought she was pregnant and sought some advice. She was 13.
March 13th	There were more screen shots and messages shared with the children's home about concerns regarding residents being in Molly's bedroom and sexual activity with both male residents, Rik, and Adam.	This information was shared with the social worker and Molly was asked by the children home staff not to allow other children into her room; an alarm was fitted to check this. Rik and Adam were spoken to and denied any sexual contact.
March 13th	Mollys looked after review was held and the children's home asked that she be moved to a more appropriate placement.	The rational for this was the complexity of her needs, the making of allegations and that 'she posed a risk to staff, visitors and residents'. This was an inaccurate picture.
April 5th	Molly says that she was raped twice by Rik in the first weeks of the placement. She reported this was in the context of cannabis use.	The police were called. Rik was arrested. Molly was interviewed. This investigation was ongoing at the time of the review and has now concluded with no further action being taken.
April 11th	Molly reported to staff that she had taken an overdose.	An ambulance was called, but due to pressures on the service they advised children's home staff to take Molly to hospital. This did not happen that evening and Molly was taken to hospital the next morning.
May	Molly left the children's home	

3. Analysis and Key Findings

3.1 The purpose of any local child safeguarding practice review (LSCPR) is to review the circumstances of one incident and consider whether this suggests that there are improvements that need to be made locally and nationally to safeguard, promote the welfare of children and to seek to prevent or reduce the risk of the recurrence of similar incidents[i]. The initial work of the panel was to identify the key lines of enquiry for the review, based on the extensive information collected and analysed as part of the Rapid Review Process. These have been framed as a series of questions which are outlined below. What is striking in the overall analysis is that there was a great deal of hard work, professional commitment to a child and her parents and careful thought to respond to a complex set of circumstances.

Question 1: What future planning currently goes on with regards to adoption placements given the known predictability of the challenges of adolescence/change/loss? How is that built into effective support so these events can be pre-empted?

3.2 The parents reported as part of this review process that they adopted Molly from a different local authority area from where they lived. Despite that local authority's recognition that Molly had experienced significant harm and abuse which was having an obvious impact on her emotional wellbeing, they offered no adoption support. The parents also made a complaint about their concerns that Molly had been emotional abused and neglected by her second foster carer; they received no response to this. They sought support from the area where they lived and were told this support was the responsibility of the placing authority. The parents did seek private help but recognise this was not sufficient to enable them to parent a traumatised child or to help Molly make sense of her early experiences.

3.3 This lack of early help was a missing part of understanding Molly and her parent's circumstances. There is little recorded information about Molly's life from the ages five to nine when this review starts. Practice in this case would have been enhanced by further discussion of this in the context of the early help assessment, two child and family assessments, the specialist assessment to make sense of the family's needs commissioned by Adoption support and the formulation by CAMHS.

Why does it matter?

3.4 Research[ii] around adoption breakdowns highlights that around 20% were caused by early concerns escalating in early adolescence and that most (80%) by an escalation of concerns as children approached puberty (around the age of 10/11). The challenges highlighted by adoptive parents were children resisting intimacy, alternating between a child wanting closeness and distance, poor self-esteem, depression and low self-esteem, self-harm, aggression and violence, inappropriate sexualised behaviours and the need to control environments, friends, siblings and family. These are all known potential impacts of early relational abuse and trauma. This question considers what action should be taken to ensure that adopters are aware of children's early lives, the possible impact (though it is always important to

recognise the individual circumstances of each child and not think harm is inevitable) particularly in the context of early adolescence, the importance of adopters being provided with help and support as early as possible.

What has been done to address this?

3.5 The local post-adoption support service are confident that they currently provide the appropriate support for adopters from the earliest stages, and they have many services and resources. They make clear the evidence base about potential outcomes, and the importance of helping adoptive parents get the right support through the child's transitions and family stages. They have a core offer to families which includes a therapeutic parenting course and Theraplay[16]. Regionally there has been agreement about a transfer protocol which outlines the expected process, accountabilities, and procedures for adoption support when families move from one area to another. Nationally there is a working group looking at what support is necessary during the first 18 months when children moving to an adoptive family to ensure there is consistency across the country.

What needs to be done?

Recommendation 1: National action needs to be taken to ensure that the needs of adopted children are addressed at key transition points such as when they move area or school. In these circumstances unless they are already known to specialist services they will come into a new area as universal children without a very clear picture of their history or needs. This is very different for the systems and processes in place for those who are care experienced. This should be considered by the national working group reviewing the support arrangements for adoption support.

[16] Theraplay is a dyadic child and family therapy. What is Theraplay? - Theraplay

Question 2: Did agencies work in a sufficiently trauma informed way which recognised the impact of Molly's past experiences on her present needs?

3.6 There was recognition across the professional network of the impact of Molly's early experiences on her current wellbeing and this was apparent in four key areas:

1. Self-harming behaviours
2. Violent and aggressive behaviours
3. Problematic sexually harmful behaviours
4. Understandable difficulties with peer relationships

Self-harming behaviours

3.7 There were early concerns about Molly's self-harm, which was clearly understood to be communication of distress and treated empathetically in line with expected child centred practice. Support and strategies were provided by the school counsellor and individual work through the first child in need plan in 2019. This seemed to help.

3.8 In June 2020 concerns about self-harm escalated and Molly was admitted to hospital. She was assessed by CAMHS, and an assessment completed. In line with NICE guidance[iii] advice was provided; distraction techniques were discussed. It was not felt that ongoing support was necessary because of the existing care plan which was focussed on plans to provide specialist input to improve parents-child relationships. The rationale was that Molly's self-harming behaviour was an expression of past trauma and she needed a safe and stable home environment. The parents became increasingly unhappy with this response. The professional network sought to provide support and to help the parents understand that Molly's behaviour was due to past experiences, which were impacting in the 'here and now' without her consciously knowing this or understanding it. This became increasingly difficult as the parents stress levels were heightened, and they experienced some family losses. Professionals were very supportive.

3.9 Over time Molly's secondary school also provided significant support regarding self-harming behaviours. They were concerned that Molly was seeking peers through social media and encouraging friends to engage with self-harming behaviour. This was addressed sensitively with Molly, the parents, and the foster carers who Molly lived.

3.10 In February 2021 the adoption support social worker made a referral to CAMHS due `to increasing concerns about Molly's escalating self-harming behaviour. They remained involved from this point to the critical incident notification and beyond. Molly's self-harming behaviour was risk assessed across the three periods of hospitalisation. She was treated with respect, empathy and understanding in line with child centred trauma informed practice. Support included helping Molly to manage her stress, use distraction techniques and coping strategies in line with best practice guidelines.

Child to parent violence; further distressed behaviour

3.11 When Molly and her parents moved to Stockport there were early concerns about her aggressive and violent behaviour to her parents; there was no evidence of this is any other context. This is not an unusual concern for children who have been traumatised.

3.12 In February 2019 the parents attended an evidence based 'child to parent violence' course lasting 10 weeks. This was a proportionate and helpful response, which took a trauma informed approach. The cause of the violence, rooted in early trauma, the impact of prolonged fear in early childhood causing changes to the way the stress hormone cortisol is produced and disposed of leading to unexplained angry outburst and anger as an adaptive response which may have kept them safe. This course also made clear that these outbursts and rages are often dissociative, with the child conscious mind not being active, the survival brain taking over and that children do not often remember what has happened.

3.13 The parents found this course useful and reported that they felt more confident, and that Molly was a 'changed' child. This did not last long, and the intensive support provided by the independent social worker as part of the April to August child in need plan provided support. This work focussed on Molly's needs, supporting the parents, and helping them to understand the roots of Molly's unconscious anger. The parents reported feelings of helplessness, depression, and an uncertainty about what to do. They were observed to be frightened of Molly and unable to provide nurturing care. They also seemed to not be able to use the techniques learnt on the child to parent violence course they attended.

3.14 Mainstream approaches to helping children[iv] who have not been taught to manage their own behaviour, regulate their emotions and who need appropriate discipline (not punishment) do not work for children with attachment problems. This is because these approaches are based on two key principles[v];

a) children want to keep parents emotionally close and want to please, any attempts to emotionally distance have an impact.

b) children believe that good things will happen to them and so rewards for good behaviour matters.

3.15 Children with attachment disorders are not sure about the safety of emotional closeness to caregivers and are alert to rejection and emotional distancing. They also do not trust rewards or their meaning. It is not clear what approaches to behaviour management the parents used or were advised about.

3.16 The specialist assessment commissioned by Adoption support appropriately recommended DDP. This approach was intended to help build relationships, addresses attachment concerns, address the difficulties that children experience when they have been developmentally and relationally harmed with the give and take of relationships and helping change children's adaptive need to control within relationships. These were all issues for Molly because of her early experiences. This therapeutic support did not take place due to

the need for a change in focus and the parent's ultimate uncertainty about the need for this support.

3.17 There was further support through the second child in need plan, but these concerns were not resolved.

3.18 Over the period February 2019 to May 2022 there were four call outs to the police regarding violence from Molly to her parents. On each occasion a crime of common assault was recorded and note that parents would not support a prosecution. A referral was made to children's social care. There was little discussion of these callouts across the professional network or what the response should be. Nationally there is no current coherent social and criminal justice response that provides help and support and a lack of pathways to support and protection for children or parents.

Why does it matter?

3.19 Research suggests that adoptive families are disproportionately impacted by child to parent violence (CPV)[vi]. Recent research suggests that nearly two-thirds (63%) of adoptive parents report their adopted children have displayed aggressive behaviour towards them in comparison to 4% of the general population. Research has shown[vii] the damaging impact CPV can have on adoptive placements. The study identified CPV as a significant factor in many family breakdowns. Adoption UK[viii] have campaigned to ensure that CPV it is viewed in the context of a trauma informed lens. What is clear is that there is currently a lack of a national and local cohesive and coherent response to concerns about CPV.

What needs to be done?

Recommendation 2: The Stockport Children's Partnership should consider developing a pathway to support an effective professional response to child to parent violence.

Problematic sexually harmful behaviours

3.20 In June 2020 there were concerns about an incident involving harmful sexual behaviours by Molly when she was 9 to a child aged 5. Appropriately a strategy meeting was convened, and it was agreed that a child and family assessment would be undertaken. This was the first incident, Molly denied that this had taken place and the alleged victim's parents did not want an interview to take place. The conclusion of the assessment had an insufficient focus on what might be causing this sexualised behaviour, despite the denials, and what this meant in the context of Molly's needs. It was agreed that work around sexual boundaries and appropriate relationships would be undertaken. In the context of this first incident this was a proportionate response. However, careful thought was needed to consider whether Molly herself had been subject to sexual harm and abuse on the past. Otherwise, the message can be that children are responsible for their own abuse, having not spotted the signs or understood boundaries/consent. This can inadvertently lead to victim blaming. Given the national gap between the

number of children who are thought to have been sexually harmed (one in ten children under the age of 16) and those who seek help (only one in the one in ten) possible sexual abuse should have been a more active enquiry. This was raised by the CAMHS Duty Practitioner in a letter to all professional in June 2020.

3.21 There were further concerns about possible harmful sexual behaviours in November 2020, which were raised by the parents, reported to school, but not seemingly responded to. This second incident was indicative of more serious concerns.

3.22 There were also concerns about Molly having shared indecent images of a friend in 2021 which were reported to the police, but it remains unclear what action was taken, or what meaning this had in the context of Molly's needs.

Why does it matter?

3.23 Referrals to local authority children's services in England during 2021/2022 where sexual abuse was assessed to be a concern included 40% harmful sexual behaviours: sexual harm by one child to another[ix]. Children's sexual behaviour exists on a wide continuum, ranging from normal and developmentally expected too inappropriate, problematic, abusive, and violent. Problematic, abusive, and violent sexual behaviour do cause developmental damage to the child who is harmed and the child who harms. The useful umbrella term is "harmful sexual behaviours (HSB)[x]". Hackett's (2014[xi]) has developed a continuum of these behaviours and Molly's behaviour fell in the range between problematic and harmful. Problematic sexual behaviours are those that are developmentally unusual and socially unwarranted, with no known overt elements of victimization, consent issues are unclear, there is a lack of reciprocity or equal power and there is a level of compulsivity.

3.24 The causal factors for problematic, harmful, and abusive sexually harmful behaviours are multi-factorial including trauma, sexual abuse, or an early introduction to inappropriate sexual material as well as individual factors such as neglect, domestic abuse and learning disabilities.

3.25 When considering HSB, both ages and the stages of development of the children are critical factors. Sexual behaviour between children can be considered harmful if one of the children is much older, particularly if there is more than two years' difference or if one of the children is pre-pubescent and the other is not. Most adolescents who display HSB are male, even considering the likelihood that abuse by girls is under-reported[xii]. It is notable that there are significantly increased concerns about sexually harmful behaviour in the children who are adopted[xiii]. This requires a trauma informed approach.

3.26 What was required was a specific HSB assessment. There were times when the AIMS2[17] was considered; this is a holistic response, but which can only be

[17] The AIM2 framework is an assessment model that offers an initial evidence-based tool that can be used to begin to consider both the level of supervision that is needed for young people and their therapeutic needs. It is holistic in nature and based on research about young people who sexually abuse others. It has recently been updated to incorporate use for girls and young people with learning difficulties.

used locally where a child or young person admits the harmful behaviour and is subject to criminal justice action; this position is supported by the NICE (2016) HSB guidance[xiv]. Research suggests that denial of harm by children is common, caused by shame and other factors, and that an AIMS2 assessment can still be helpful. The Brook traffic light tool[xv] could also have been a useful framework for assessment, though now needs specific training and a licence for usage. The Simon Hackett/NSPCC[xvi] framework also provides a useful assessment tool.

What can be done about this?

No recommendation is made because there is currently a task and finish group in Stockport working on an improved response locally to HSB.

Predictable issues with peer relationships

3.27 There were concerns raised by the parents about peer relationships when Molly moved to the Primary school in January 2018. Support was provided. These concerns continued over time, and the adoption support team provided support to schools. This was good practice.

3.28 The secondary school also put support mechanisms in place. Individual support was provided though the independent social worker and the CAMHS worker.

3.29 As time went on the narrative was that Molly struggled with friendships per se, as opposed to her early attachment history, adaptive need for control and issues of trust; there was a lack of a consistent approach to early trauma in this context.

The issue of language

3.30 Overall, all professionals recognised the impact of early trauma on Molly. As time went on there was a drift to more negative and victim blaming language across records, including her being described as ‘manipulative’, suggesting this was an internal characteristic, ‘damaged’, rather than living in damaging circumstance, having ‘problematic behaviour’, rather than never having been enabled to regulate her emotions. One set of records talks about her ‘pretending to cry’ but appearing with no tears or red eyes and recovering too quickly. There was a growing professional belief evident in records that Molly’s presenting concerns went beyond ‘her past experiences’ and represented a sense of an integral and internal mental health need as opposed to mental health needs cause by ‘what has happened to you’ not ‘what is wrong with you’. This unintentional drift challenged the concept of child centred trauma informed practice.

Why does it matter?

3.31 There is now a large body of research and theoretical evidence of the profound long-term impact that repeated early trauma has on children’s development[xvii] [xviii]. The impact of pre-and post-birth toxic environments, birth trauma and illness, neglect, physical and sexual abuse, and multiple separations, singularly or in combination, cause impairment to traumatised children’s psychological, neurological, and physiological development. In

essence the brains, bodies and neurological pathways of these children become 'hard wired' to the expectation of trauma, an expectation that impacts the way they understand themselves, other people, especially those in a parenting role, and the meaning they give to experiences. This developmental and relational trauma[xix], which takes place in the context of family relationships, is fundamentally different from single incident trauma experienced by children who were previously coping and developing appropriately.

3.32 Children's early relationships and interactions with adults are essential to provide the organising framework and representational models for children's future relationships. Children who have experienced parenting relationships and an emotional environment characterised by fear, anger, hostility, pain, intrusiveness, withdrawal, and disengagement learn to see others as a threat, rather than a source of comfort. They are left without a template for positive social interactions; human contact becomes a source of stress and anxiety. To survive, children must develop survival skills and powerful defence mechanisms to protect themselves from further pain and loss. Their ability to assess safety and danger becomes skewed, and they often have difficulties understanding other peoples' feelings behaviours and intentions. This all makes the world a scary and hostile place. The legacy for these children is that their experiences of harm can make them fragile, wary, anxious depressed, angry, emotionally vulnerable, angry, aggressive, and at times without to make healthy relationships.

3.33 There has been a professional and community belief or hope that when children are removed from abusive and harmful situations and they are placed in loving homes with loving people, that this will be enough to help them recover. Children/young people who move to live with alternative caregivers, family, friends, or residential care arrive with established relational, emotional, and behavioural patterns and many children transfer the behaviours, feelings and responses they experienced with their birth parents to their new carers[xx]. They may show a range of controlling behaviours that help them to feel they are in charge of their own care and protection. This can annoy and upset adults who are trying to care for the child and can make them become overly authoritarian or aggressive[xxi]. This serves to confirm to the child that they should not let down their defences and that they need to remain in control. There is a danger that instead of children/young people's responses being seen as manifestations of distress and often when developed they were normal adaptations to abnormal abusive circumstances, they become seen as internal and unchangeable characteristics of the child/young person. They can be described 'as controlling', 'unemotional, 'unempathetic' 'unable to show emotion or talk about feelings.

What needs to be done about this?

Recommendation 3: Stockport Children's Safeguarding Partnership should seek assurance that partner agencies have in place guidance regarding trauma informed recording, which addresses victim blaming language and

ensures that professionals record with the child in mind. Understanding that the child may one day ask to see their records.

Question 3: How well did agencies recognise the need to support this family to prevent a family breakdown?

3.34 All the agencies that worked with Molly and her parents recognised Molly's needs and the pressures that the parents were under in parenting a traumatised child.

3.35 Molly's primary school were proactive in recognising Molly and her parents needs from the moment she moved to the school in January 2018. They ensured that Molly was provided with support through a primary jigsaw counsellor and sessions were also held with the parents.

3.36 Over an eight-week period concerns escalated, the parents talked about their worry that they would not be able to continue to parent Molly safely, because of her violence and self-harm. The primary school appropriately completed an early help assessment, a referral to Child and Adolescent Mental Health Services (CAMHS) and Adoption support services. They were proactive and responsive to the family's needs. This was also true of the paediatrician that saw Molly, who also supported the parents and made onward referrals to CAMHS.

3.37 The adoption support team had not had any previous contact with the family, and they recognised the need for additional services and started the process for commissioning a speciality assessment of Molly's therapeutic needs. This needed to be put out for tender in line with their policies and procedures which this led to a considerable delay. In the meantime, they also and made a referral to Stockport children's services and provided immediate support through the provision of a child to parent violence course. The parents declined support from CAMHS at this time.

3.38 Stockport children's services completed a child family assessment, and this led to a child in need plan. The child and family assessment focussed on the likelihood of the adoption placement breaking down, the impact of Molly's early experiences, as opposed to recent history, and a plan was put in place. An independent social worker supported Molly and the parents. This work recognised the needs of the parents and the pressures they were experiencing.

3.39 The parents reported that the support from school and the social worker had helped and that they felt the family circumstances were more settled and the child in need plan stepped down to a Team Around the Child plan (TAC) after a period of four months in July 2019. This was when Molly was moving from Primary to secondary school, when the specialist support through the school counsellor would be ending. Given this significant transition point, and the fact that the specialist assessment to consider Molly's therapeutic needs it would have been more appropriate to continue the ongoing support. The secondary school were made aware of Molly's history and put appropriate support in place for her. At this point the parents had minimal support.

3.40 The specialist assessment did not start until September 2019, six months after the original referral and would conclude three months later, December 2019. after this. It was a good assessment, which made clear Molly and her parent's needs. There was a long-term plan agreed which started with Dyadic Developmental Psychotherapy (DDP) for the parents and sensory support for Molly. These services took some time to commission, and the DDP started in April over a year after the initial concerns were raised. This was then halted, because it became clear that couple counselling was required because of the stress the parents were under. This started quickly, but the parents eventually felt this was not the right type of support for them and wanted to focus on Molly's needs.

3.41 The sensory support for Molly started in January 2020, sometime after it was recommended, and like much of this specialist support was instigated at a time when the circumstances had become more entrenched, and so did not meet the previously addressed needs.

3.42 In June 2020 there was a further child in need assessment by children's services, and recognition that there was a need for intensive support to prevent the adoptive placement breaking down. This support was provided, and a social worker and independent social worker were in almost daily contact.

3.43 There was an escalation of concerns in September 2020, with the parents asking for Molly to be assessed by CAMHS. This took place, but CAMHS took the view that Molly's distressed behaviour was an indication of early trauma and suggested the professional network stick to the plan to focus on Dyadic Developmental Psychotherapy (DDP) and building family relationships. This was agreed. Work continued, but in May 2020 the parents felt that Molly was not safe at home and needed to come into care. They reported that this was not an easy decision for them.

3.44 In February 2021 the adoption support social worker referred Molly to the home treatment team at CAMHS because of escalating concerns. It was agreed that CAMHS would provide support to Molly and her parents, and this was ongoing until the critical incident.

3.45 There was clear identification by the professional network of the need to support this adoption placement, and a recognition of the issues for both Molly and her parents. Professional worked hard to provide support. The delays in the specialist support seem to have had an impact; there were times when the parents had little support in the transitions between different support and services. This meant they felt they were on their own dealing with the distressed behaviour of Molly and trying to make sense of it. More recently they considered that professionals found it hard to acknowledge the struggle of addressing Moly's complex trauma needs. They did not feel that professionals understood that they knew that Molly had complex needs arising from early trauma, which they had found difficult to deal with and had themselves felt secondarily traumatised with. They believed there was an over emphasis on 'positives', and what a great child Molly was. They did not dispute this but wanted the trauma indicators to be acknowledged.

Why does this matter

3.46 Children who are removed from their parents, families and siblings experience huge feelings of loss and separation[xxii], regardless of the chaos, abuse, or uncertainty they have come from, which makes them prone to chronic fears and anxiety. Their response can be withdrawal or constantly asserting themselves, trying to be in control of everything. An imbalance between age-appropriate dependency versus autonomy can be exacerbated and the already diminished trust in adults and self is increased. These children, understandably, want to make sense of their 'life-story' and identity. Bessel van der Kolk[xxiii] with his concept that 'the body keeps the score' (Van der Kolk 1994) highlights that, even when traumatised children move to safe and secure homes, the feelings and sensations that underlie their dissociative responses are still there.

3.47 Evidence makes clear that caring for these children who have lived in damaging circumstances can be difficult. Living with an angry, aggressive child can be traumatic since the nature and extent of the behaviours they display are not single incidents, but ongoing lived experiences that permeate every facet of family life, often for many years. Traumatised children are frequently described as hypervigilant; parents may also become hyper-vigilant, unable to relax and enjoy times when their children are more settled. They may have internalised a belief that, if they let their guard down, disaster is likely to follow.

What further work needs to be done?

This is addressed in ongoing work highlighted in question 1.

Question 4: How was Molly's contact with birth family handled and managed by agencies.

3.48 it is not exactly clear when Molly started to seek to have contact with her birth family, but this seems to have started in June 2021. There were immediate concerns about this contact and the allocated social worker at this time undertook direct work to understand what Molly wanted. There were attempts to put some structure around the contact, with variable success. It became clear that some members of the family were supportive and a helpful influence.

3.49 Birth mother was more unpredictable; she posted pictures of significant self-harm. Molly put some boundaries around this and was supported by both her social worker and her CAMHS mental health practitioner. Contact with the family is now more regulated.

Why does it matter?

3.50 Research suggests that contact between birth families and children who are adopted requires careful consideration in the context of what is in the best interests of the child. For Molly there is a lack of clarity regarding what thought was given to this contact when she first became care experienced. Careful planning is required, and this was apparent at this important stage.

What is being done about it?

There is no recommendation because the regional adoption support agency are developing guidance for professionals about contact with birth families, particularly in the context of social media. The University of East Anglia (UEA) has produced a material[18] to support decision making regarding post adoption contact. These could be disseminated as part of this review process.

Question 5: When seeking to place Molly away from home did the commissioning and matching process take account of the known needs of Molly.

3.51 In May 2020 Molly's parent felt that she needed to be placed temporarily away from home for her own and their safety; they report this as a sad moment given their love and commitment to her. The local authority agreed with this, and careful thought was given to where she would move. Initially this was to a foster carer who had provided short breaks for Molly in the recent past. This was a short-term solution in a crisis. Care was taken to find a more permanent home and a foster family placement was considered the most appropriate move. This was a six-month period of relative stability for Molly, with regular contact with her parents and continuation of school and CAMHS support. Sadly, there was a period in October/December where Molly's distress manifested in escalating self-harming behaviours. These concerns were responded to, but ultimately the foster carers said they could no longer keep Molly safe.

3.52 In December 2020, careful thought was given to Molly's next move. The local authority were aware of the impact of placement instability on children's outcomes. It was agreed that she would be placed with a specialist therapeutic foster carer who had no other children living with her. The plan was that this foster carer could focus on Molly's needs. Despite the well thought out intentions, this arrangement did not work. Molly was unhappy, lonely and isolated. She wanted to move, and not to a family placement.

3.53 The local authority convened a legal planning meeting in early 2021 to discuss the next steps for Molly. This was attended by all agencies who were supporting her. It was agreed that a placement in a children's home would be an appropriate move given her needs; this was in the context of thinking that she would return home to her parents. The rationale for not choosing a further family style placement was clear, despite her young age.

3.54 The social worker and commissioning team were charged with finding an appropriate placement for Molly. They were aware of the pressures of this given how unhappy Molly was, but aware of a shortage of appropriate placements. This shortage meant that Molly's desire to move was delayed, and that it was hard to deliver child centred practice. A children's home was identified in February 2021 and was considered an appropriate match; she moved in quickly. A good placement referral was made outlining all her needs.

[18] Contact after adoption | Resources for practitioners (rip.org.uk)

The history was provided, and immediate issues regarding self-harm, concerns about situational violence to parents and historical abuse and neglect.

3.55 The children's home asked that Molly move four weeks later; that they felt she needed a more specialist placement; the lack of education provision at this time was also a worry for them. They also said that they were concerned about Molly making 'allegations' and that 'she was a risk to staff, visitors and other young people'. This risk was not substantiated in any way and during the period of this review there remains no evidence of it. It is of concern that as a result of Molly speaking out about sexual harm, and growing concerns about poor sexual boundaries and safety in the home not being addressed, that Molly, who was aged just 13, was asked to leave. The social worker was unhappy with this decision but felt she could not challenge it. The Independent Reviewing Officer does not appear to have seen the letter of notice and so did not challenge it. It should have been challenged. It is of concern that such a serious assessment of a child can be made, without any evidence, can be recorded and likely travel with time over time in their records. This was serious victim blaming which held Molly responsible for any harm she had experienced and did not address the behaviour or possible concerns of other young people.

3.56 The children home were aware that this further move would impact on Molly, and they said she could stay for longer than the normal notice period to ensure that the next move was appropriately planned. Molly has since had two further placements.

3.57 There was good planning for Molly, and careful thought given about her needs, however she had now had four moves of home in the review period. This was in addition to the four moves in her early years creating more instability for her and more experience of trauma and loss.

Why does it matter?

3.58 The stability of home environments for all children is important and particularly for those who need to move from their permanent families. Family moves, planned or not, can have a very detrimental effect on children. Research[xxiv] has shown that, after controlling for background factors or when children enter care with no discernible mental health problems, placement moves are associated with the development of emotional and behavioural difficulties. It is not surprising that moves can be so damaging. Children crave stability and moves create stress, which if not supported by trusting relationships can result in children's development being negatively affected[xxv]. Placement instability reduces a child's opportunities to develop secure attachments. It may also worsen any existing behavioural and emotional difficulties[xxvi], making it more difficult for children to establish relationships with carers and contributing to further placement breakdown and rejection[xxvii].

3.59 The children's commissioner review of how well children's homes meet the needs of children has expressed concern about the number of children with

complex needs who are evicted at short notice, creating uncertainty and instability which can be self-reinforcing; when children's care arrangements break down, this can impact negatively on the next move and make it more likely that this breaks down.

3.60 There are national concerns about the low availability of high-quality residential care for children with multiple needs arising out of early abuse and neglect and who have been affected by developmental and relational trauma. This has led to a position of high competition for places, with children being left without a suitable place to live that meets their needs. It has also created immense pressure on local authority placement teams. The placement at the children's home was right for Molly, but the need to move her after only four weeks meant finding another children's home. On this second occasion there were few options and Molly stayed longer than her notice period. The next placement was less suitable, but the only available choice. This then broke down. Fortunately, a new children's home was found where she is now settled.

3.61 Molly's circumstances highlight that the system of residential placements is now dominated by low availability, high demand, high cost and high competition. This means that those children with the most complex needs are often offered places and placement options which are not suitable for them.

What should be done about it?
Recommendation 4: This LCSPR is one of many nationally where there have been concerns about the impact on children and young people of the cost and shortage of appropriate placements for traumatised children. Stockport Safeguarding Children's Partnership should suggest that this is something the National Panel could consider in terms of creating change for these children.

Question 6: Was Molly kept safe from harm when placed at the children home?

3.62 Molly moved into the children's home in February 2021 at the age of 13. Good information was shared about her circumstances and history, both positive and negative. This was a balanced picture. The children's home did not share concerns about one of the resident's historically sexually problematic behaviour. It appears that a lack of a criminal evidence and a lack victim disclosure was confused with more general worries about possible harmful sexual behaviours and what they might mean. The children's home also report they were unaware of allegations of rape about this young person by a 'girlfriend'.

3.63 The day after Molly was moved to the children's home there was a conversation between the home treatment team (CAMHS) and children's home staff about Molly's needs. This confirmed concerns about distress in the form of self-harm, history of violence at home and difficulties with peer relationships. The home treatment team expressed surprise that there was no

waking staff available at the children home and reported that they always visited Molly in twos. This was because they did not know her well, and there had been concerns about violence at home. In reality this was only to the parents she had never been violent outside of home. It is not clear why, but this conversation was recorded as also including concerns that Molly had made false allegations about professionals, she had contact with and she had also taken photographs of professionals without their permission; it was worryingly recorded that Molly '*massaged the truth'*. There is no evidence that Molly had made any false allegations about professionals but had taken photographs of professionals she thought had helped her; she was asked not to do this, and this did not happen again.

3.64 It is unclear how this misunderstanding came about; the home treatment worker agrees information was shared about the photographs but not about the false allegations or Molly '*massaging the truth'*. The children's home did not seek clarity about this seemingly new information from the social worker. This lack of clarity meant that a perception was created that Molly made up allegations; about what remained unquantified. The custom and practice of the home treatment team of having two workers to visit also reinforced this belief.

3.65 In early March, the children home staff became aware of discussions related to allegations that Molly had been sexually assaulted. Molly was spoken to, and she said that she had been sexually assaulted two days earlier by Jay (aged 15) a friend of one of the residents, Rik who was aged 16. The police were informed; the children's home staff told the police that Molly had only been out of their sight briefly; the implication being that this incident may not have happened and hampered the police inquiries; these were concluded with no further action due to insufficient evidence.

3.66 Molly was provided with support by children home staff and her social worker. The children home planned to complete work with Molly on keeping herself safe and safe relationships. This was work that had previously been completed with Molly by the social work team some years earlier, and unintentionally could have implied a 'victim blaming' approach. She had been harmed by another young person and this 'educational approach' could imply she needed to do more to keep herself safe.

3.67 The following week information was shared by a previous female resident of the children's home that Molly had spoken about earlier sexual activity with the two male residents, Rik and Adam and that she was pregnant (this information was in the form of text messages and TikTok images). Molly confirmed she thought she might be pregnant, but not by either Rik or Adam.

3.68 These rumours continued the next day. Rik and Adam were spoken to, but they denied any sexual activity. Molly's phone was checked, and this confirmed that all the residents had been in each other's bedrooms (not sure what time of day), and this was in the context of concerns about Rik's cannabis use. Molly was told not to allow anyone in her room and an alarm was fitted. Although it was made clear in the recording of this incident that

Molly was not 'to blame' and 'she was not in trouble' the spotlight was on her as opposed to broader concerns about a worrying picture of possible sexual harassment and harm. This focus on Molly alone is shown by the fact that there were no critical incident records made about concern about either Rik or Adam. The children's home were aware that there had been allegations of harmful sexual behaviour by Rik. The children's home needed to focus on the environment, which was enabling sexual harm to take place, and consider how best to manage this.

3.69 A few weeks later, in April, Molly spoke about being sexually assaulted by Rik within the first two weeks of living at the children's home. The incident was said to have taken place when Rik was in Molly's room and smoking cannabis. This would correspond with the timescales of the concerns raised in March. The children's home contacted the social worker and the police. Rik was arrested and moved from the children's home. It is clear that the children home staff provided molly with individual support, but they did not see that this was an issue related to how children were kept safe from harmful sexual behaviours, a known and likely risk. They asserted that they could not see how the incident could have taken place because the staff would have known if the residents were in each other's rooms, smoking cannabis and they would have addressed this at once. This assertion both implied further victim blaming, but also undermined Molly's version of events of sexual harm. The police have shared with the reviewer that this assertion 'that it could not happen because of the staff vigilance' could also undermine the police investigation, casting doubt on Molly's disclosure.

What is the practice concern?

3.70 There is considerable concern nationally about the level of sexual abuse, harm, and harassment, both in person and online that girls and young women experience in all the contexts that they meet, such as school, clubs and sports activities. This has led the DfE to reissue 'keeping Children Safe in Education[xxviii], [xxix] to highlight the need for a cultural shift within schools, to create safe environments and cultures. The focus is on a 'whole school approach' as opposed to just holding individual children and young people who sexually harm or those that have been harmed responsible. The Centre of Expertise on Child Sexual Abuse has also produced 'Safety Planning in Education' to help schools address this extremely serious issue.

3.71 The Independent Inquiry into Child Sexual Abuse (IICSA: Jay 2022[xxx]) also raised concerns about child sexual abuse in institutional settings, which was characterised by denial, a focus on the reputation of the settings and victim blaming. Although this was largely focussed on adults who harmed children and young people, there were also concerns about the response to harmful sexual behaviours; children who harm other children.

3.72 Children's homes need have a culture characterised by 'how could sexual harm happen here' as opposed to 'sexual harm cannot happen here' and a process whereby adults and children are encouraged to speak out about all forms of sexual harassment and bullying, without minimising it as 'banter' or

explaining it away. That children will know they will be heard, believed and made safe when they speak out about being sexually harmed or worries that they may sexually harm others and a clear safety planning process is in place. The children's home where Molly lived has very good child focused information for children and young people and clear safeguarding policies regarding staff, it does not have any framework or policy regarding harmful sexual behaviours by children and young people. It also does not have a clear police about recording which is trauma informed and non-victim blaming. There should have been a more explicit discussion about how the young people in the residential unit would keep themselves sexually safe.

What needs to be done:

Recommendation 5: When seeking placements for children the commissioning team in Stockport should seek reassurance about harmful sexual behaviours policy and systematic approach to keeping children safe from sexual harm from all settings.

Recommendation 6: Stockport Children's Partnership to propose that the children's home develop a harmful sexual behaviours policy and systematic approach to keeping children safe from sexual harm.

Recommendation 7: Stockport Children's Partnership to propose that the children's home develop guidance about trauma informed and non-victim blaming record keeping.

Recommendation 8: The social worker for Molly to review how far the assertion that 'Molly posed a risk to staff, visitors and other children' has been incorporated into other case records, assessments, looked after reviewing materials and placement referrals and make sure these are amended.

Recommendation 9: The Chair of Stockport Children's Safeguarding Partnership should write to the national panel to find whether other LSCPR's have highlighted a lack of guidance within children's homes about HSB and whether this issue is currently being sufficiently addressed through Regulation 44 Visits.

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