Rochdale Borough Safeguarding Childrens Partnership

Local Safeguarding Children Practice Review

- Executive Summary - Milo and Ben

Purpose of the Review and Overview

This Local Safeguarding Children Practice Review (LSCPR) was commissioned following a serious incident involving harmful sexual behaviour between siblings within a family already known to services. The purpose of the review was to identify system learning to strengthen multi-agency safeguarding practice and reduce the risk of recurrence.

A rapid review determined that the case met the criteria for a full LSCPR due to the complexity of the children's lived experiences, the sustained multi-agency involvement over a number of years, and the need to better understand how professionals recognised, assessed and responded to cumulative risk. The review considered recent practice alongside relevant historical information to understand patterns of harm over time.

The review has been conducted with a focus on system learning rather than individual blame. It recognises the challenging context in which professionals were operating in and seeks to understand decision-making at the time. Contributions from family members and a Practitioner Event' provided valuable insight, particularly highlighting the need for stronger support to parents in managing complex behaviours and improved communication and inclusion in professional planning.

Learning from this review aligns with local and national work to strengthen responses to child sexual abuse and harmful sexual behaviour, reinforcing the importance of consistent, whole-system implementation.

Background and Context

The children had longstanding involvement with a range of services, including Early Help, Child in Need and Child Protection planning. Concerns throughout this period included neglect, parental mental health difficulties, domestic abuse, and indicators of harmful sexual behaviour.

While there was extensive professional involvement, sustained improvements in the children's safety and emotional wellbeing were not achieved prior to the incident. The children experienced cumulative harm over time, including instability in care arrangements linked to parental mental health crises, and exposure to inappropriate risks, including online harm.

There were earlier indicators of concerning behaviours, including sexualised behaviour and emotional distress, which were not consistently recognised or responded to through robust safeguarding pathways. This meant that opportunities for earlier protective intervention were missed.

Key Findings and Learning

Recognition of Risk and Cumulative Harm

A key finding is that risk was not consistently understood cumulatively across agencies. Indicators of neglect, emotional harm and harmful sexual behaviour were often considered in isolation, rather than being analysed together as part of a broader pattern of escalating risk.

The absence of effective multi-agency impact chronologies limited professionals' ability to identify patterns over time. In addition, a strong focus on potential special educational needs and parental mental health, in the absence of a sufficiently robust safeguarding lens, reduced the effectiveness of interventions and delayed more decisive protective action.

Children's Lived Experience

Although professionals undertook direct work with the children, their lived experiences were not consistently central to decision-making. Greater weight was often given to requiring a verbal disclosure from the children than to being curious about what the behavioural indicators meant, despite the children presenting with a range of concerning behaviours over time.

These behaviours included emotional dysregulation, sexualised behaviour and distress, indicators of neglect which reflected underlying trauma and unmet safeguarding needs. They were frequently attributed to other factors rather than explored as potential indicators of harm, resulting in missed opportunities for earlier intervention.

Assessment, Planning and Professional Curiosity

Assessments and plans were not always sufficiently analytical or reflective of the recurring nature of risk. There was limited use of evidence-based tools to assess neglect, harmful sexual behaviour and child sexual abuse, and insufficient professional curiosity regarding why risks persisted despite repeated interventions.

Decisions to step down or close the family to services were at times made without updated, robust assessments, and there was evidence of professional over-optimism when short-term improvements were observed. This impacted the quality and effectiveness of safeguarding planning.

Multi-Agency Working and 'Think Family' Approach

The review identified inconsistencies in the application of a 'Think Family' approach. Adult services were not always fully engaged in multi-agency safeguarding activity, and information sharing was not consistently timely or comprehensive.

Risks relating to adult vulnerabilities and family context were not always effectively integrated into safeguarding planning for the children. Workforce challenges, including staff turnover, further affected continuity and the consistency of professional oversight, contributing to fragmented responses.

Good Practice

The review also identified areas of effective practice. Professionals across agencies developed positive relationships with the children and undertook meaningful direct work to help them understand their experiences. There was evidence of coordinated responses at critical points. Information sharing improved following key disclosures.

There were examples of proactive safeguarding arrangements, including work to strengthen parental involvement and planning to reduce identified risks. These examples demonstrate the commitment of the professionals working with the family and provide a foundation on which to build improved practice.

Conclusion

The review concludes that the children experienced cumulative harm over an extended period, which was not consistently recognised or addressed through coordinated safeguarding action. While there was sustained professional involvement, system weaknesses limited the effectiveness of responses.

A particular feature was the focus on individual presenting issues, such as parental mental health or potential special educational needs, without sufficient integration into a holistic safeguarding analysis. This, alongside inconsistent escalation and limited multi-agency coordination, reduced the impact of interventions.

The findings highlight the need for greater consistency in recognising and responding to child sexual abuse and harmful sexual behaviour, embedding trauma-informed practice, and ensuring that children's lived experiences are central to decision-making.

The learning from this review aligns closely with the findings of the local CSA thematic review and national learning, reinforcing the importance of sustained, system-wide implementation to improve outcomes for children.

Key Recommendations (Summary)

The review makes a number of recommendations to strengthen safeguarding practice across the partnership, including:

- Strengthening the recognition and response to child sexual abuse and harmful sexual behaviour, including where disclosure is limited.
- Embedding the use of multi-agency impact chronologies to support understanding of cumulative harm.
- Embedding the RBSB Neglect Strategy across the workforce
- Improving the quality of assessments, professional curiosity and management oversight, particularly at key decision points.
- Embedding a robust 'Think Family' approach, ensuring effective collaboration between adult and children's services.
- Supporting the workforce through training, supervision and clear guidance to balance considerations of trauma, additional needs and safeguarding risk.
- Ensuring that learning from local and national reviews is consistently implemented across the system to improve outcomes for children.