Local Child Safeguarding Practice Review

Child T

OVERVIEW REPORT

v0.4

November 2022

Jon Chapman

Acknowledgements

Governance

The author can declare that he has no conflict of interest in completing this review, and that he is independent to Coventry Safeguarding Adults and Children Partnership Board and partner agencies. The report has been commissioned by, and written for the Partnership, and overseen by a multi-agency child safeguarding practice review panel of local senior managers and practitioners from the following agencies:

- Coventry City Council Children's Services
- West Midlands Police (WMP)
- Coventry & Warwickshire Clinical Commissioning Group (CWCCG)
- South Warwickshire NHS Foundation Trust (SWFT)
- Coventry & Warwickshire NHS Partnership Trust (CWPT)
- University Hospital Coventry & Warwickshire (UHCW)
- NHS England (Midland)
- Coventry City Council Legal Services *(provided the Family Court Judgement Abstract)*
- Mountain Healthcare – Horizon Sexual Assault Referral Centre (SARC)
- Coventry City Council Mental Health Services
- Coventry City Council Education/SEND & Specialist Services
- National Probation Service
- NSPCC

The details of the child and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Foreword

This case has a number of unusual features, the most prevalent of which is that there has been a Family Court Judgement that initiated the rapid review and therefore the case review. This route is discussed within the report.

It is clear that tackling all aspects of child sexual abuse is now a priority for the Coventry Safeguarding Children Partnership and this review will help underpin some of the developments that are already taking place.

This includes work in the partnership on training and embedding information regarding accessing the SARC and early identification of cases which may present learning opportunities.

Contents

1.0 Introduction and background

1.1 This review will focus on the case of Child T. Child T was 2 years old when presented to hospital by his mother on 21st July 2020. This followed a call that the mother had made to the health 111 service. The mother was raising concerns about bruising and soreness to T's testicles, penis and bottom. At the hospital T was examined and extensive bruising was noted.

1.2 A referral was made to Children Social Care (CSC) and a strategy meeting was convened. Whilst consideration was given to the injuries being non accidental in nature there was no consideration by any of the parties at the strategy discussion of the potential of sexual abuse.

1.3 During the course of his admission T was examined on three occasions by different doctors, two of these being paediatricians. It was not until 3 days after his admission and initial examination that sexual abuse became a consideration. A sexual offence medical did not take place until 29th July 2020, some 8 days after T's admission into hospital. Although there was a lack of consideration of sexual abuse at an initial stage, it was recognised that the injuries were non-accidental and measures were put in place to protect Child T. On 13th August 2020, the designated doctor undertook a medical as part of an initial health assessment as T was now a looked after child.

1.4 The case was not initially considered under the rapid review process[1]. In November 2021, The Family Court handed down a judgement in T's case[2]. A rapid review was considered and submitted in November 2021. A thorough scoping and review discussion took place, and a decision was taken by the Local Safeguarding Partners that the learning from this case has been extracted through the rapid review meeting and did not feel that a Safeguarding Practice Review was necessary. The panel did however recommend that the Partnership consider completing an audit/deep dive of a cohort of child sexual abuse cases to understand if the issues raised in this case were more widespread.

1.5 The Partnership decision was communicated to the National Child Safeguarding Practice Review Panel who replied to The Partnership at the end of December 2021, with a view that a Local Safeguarding Practice review should be considered on the basis that there was significant local learning to be drawn from the case. The National Panel were not assured that some of the key questions relating to evidence gathering, strategy meetings and referral to out of hours service provided by the SARC, were fully addressed.

1.6 After consideration and discussion with a representative of the National Panel it was agreed that the Local Safeguarding Practice Review would be conducted in the form of an in-depth audit of 10 cases, which had been referred on the basis of sexual abuse.

[1] Rapid Review, Working Together, 2018 - The aim of a rapid review is to enable safeguarding partners to: • gather the facts about the case, as far as they can be readily established at the time • discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately • consider the potential for identifying improvements to safeguard and promote the welfare of children • decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

[2] An anonymised version of that judgement was published by the Faculty of Forensic and Legal Medicine (FFLM) in March 2022

1.7 This overview report will seek to bring together the learning from the rapid review, Family Court judgement and the audit process, to identify the learning themes and make recommendations to address them. This review also undertook a specific practitioner's reflective workshop on the T case and those discussions are reflected in this report.

1.8 The author of the review met with members of the family, including those who were still in contact with Child T, there was also an opportunity to speak to Child T's Court Guardian. It was established that there were no known concerns prior to Child T being presented to hospital. Some matters were raised which were outside of the scope of this review and these were highlighted to relevant agencies.

2.0 The Family Court Judgement

2.1 The case was heard in the Family Court in November 2021, some 15 months after the case had initially presented. The fact-finding hearing was undertaken as the Local Authority asserted that T had sustained inflicted injuries, including (but not limited) to his genitals and anus, which were caused by someone who had been caring for him. The court heard 15 days of oral evidence and submissions and made the following determinations.

- All of T's injuries had been inflicted by one (or both) of two possible individuals who had care for him at the relevant time.
- He suffered genital injuries as a result of an inappropriate and excessive force being applied to his genital area.
- He suffered anal injuries as a result of a penetrative act or attempted penetrative act.
- These injuries were caused on one or more occasion by an adult subjecting T to either a sexual assault or a physical assault without sexual motivation.

2.2 The Judge commented *'Over the course of the clinical evidence I had become concerned by what appeared to be lamentable delays between T's arrival at hospital with apparent genital injuries and his examination by specialist doctors. It was sadly the case that it took eight days from the time T was first seen in the A&E department to his examination in a sexual assault referral centre despite clinicians observing injuries to his genitals and anus shortly after he first arrived at hospital.'*

2.3 The Judge made it clear that the reason for the supplementary and abridged Judgement was as it: -

- May be useful to those making commissioning decisions in relevant areas of health services and social care.
- May assist anyone who may enquire why it took so long for T to receive the medical examinations his case required.

2.4 After considering the case in detail the Judge drew the following conclusions on the matter of the delay in achieving a sexual offence medical for T.

- There was a lack of early recognition of the need by all professionals of the desirability of a specialist examination.
- There was a lack of clarity over the referral process.

- There was an apparent lack of service provision at weekends with no apparent alternative provision being available.

These areas of concern will be addressed in the discussion section but it has been established the third point regarding the apparent lack of service on a 24/7 basis is not correct. The SARC delivers a full 24/7 service. That said, it does feed into the second point regarding a lack of clarity over the referral process and it would be a concern that those involved in informing the court were not aware of what the process should be to access the service.

2.5 The Judge also expressed a concern regarding the lack of a formal protocol between police, the Sexual Assault Referral Centre (SARC), the Local Authority and hospitals, although information was provided that process flowcharts were being formulated at that time (November 2021). There was at the time a referral process in place, the issue being how well understood this was within the partnership.

2.6 As a result of the court process the Designated Doctor for Coventry contacted the Court and stated an intention to refer the case for a rapid review in pursuant of Working Together 2018.

3.0 The Rapid Review

3.1 The rapid review in the T case took place in November 2021. This involved a discussion between all the agencies which were involved providing scoping information and was independently chaired by the Safeguarding Partnership Independent Chair. The below organisations participated in the meeting.

Job title	Agency
Independent Chair	Coventry Safeguarding Children Partnership
Business Manager	Coventry Safeguarding Children Partnership
Quality Assurance Manager	Coventry Safeguarding Children Partnership
Development Officer	Coventry Safeguarding Children Partnership
Strategic Lead - Looked After Children	Children's Services, Coventry City Council
Team Manager – Looked After Children and Permanency Team	Children's Services, Coventry City Council
Detective Inspector	Child Public Protection Unit, West Midlands Police
Consultant Paediatrician and Designated Doctor for Child Safeguarding	Coventry and Warwickshire Clinical Commissioning Group
Solicitor	Legal Services, Coventry City Council
Lawyer	Legal Services, Coventry City Council
Head of Safeguarding	South Warwickshire Foundation Trust
Lead for Safeguarding	University Hospital Coventry & Warwickshire

Head of Safeguarding	Coventry & Warwickshire Partnership Trust
Assistant Director	NSPCC
Director of Nursing	Mountain Healthcare
Contract Manager	NHS England
Senior Lead - SEND	SEND & Specialist Services, Coventry City Council
Deputy Head	Coventry Probation Delivery Unit, National Probation Service
Team Manager	Mental Health Services, Coventry City Council
Sexual Assault & Abuse Strategy Coordinator	Public Health, Coventry City Council

3.2 The rapid review meeting highlighted the following areas of learning:

- There needs to be a lower threshold for a specialist examination – genital injuries are unusual unless specifically targeted and specific targeting of the genitalia in physical abuse should raise concerns about sexual abuse.
- Health professionals need more knowledge and education around identifying and responding to injuries that are indicative of child sexual abuse during a child protection medical. It was recommended that a guide is produced and shared with all paediatric doctors in the city.
- Non-health professionals need a better understanding about the types of child protection medical examinations. Sexual abuse examination is a specialist field.
- Practitioners need to be more professionally curious and 'think the unthinkable' especially when presented with evidence of both physical abuse and potential sexual abuse and have the confidence to challenge and open further discussion regarding injuries
- When a Section 47[3] enquiry is ongoing and new information is shared regarding significant harm, a further strategy meeting must be held. A further strategy meeting should also be convened if a child makes a disclosure of abuse.
- Professionals need to be clear around the referral process into the SARC (who, when and how) and the availability of the SARC outside of normal working hours.
- A potential issue of national significance is around the SARC referral procedure, the lack of awareness of their out of hours service provision and their lack of participation in strategy meetings. This issue will also be flagged at the next West Midlands regional meeting for Safeguarding Partnership Business Managers.

3.3 The rapid review also identified that the Partnership would undertake a deep dive audit into a cohort of children in similar circumstances to T. The audit would seek to understand

[3] Where a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by Section 47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child. (Regional Child Protection Procedures for the Est Midlands)

how the system works for those children who do not make a disclosure or allegation but there are concerns about sexual abuse.

3.4 The rapid review concluded that a Local Child Safeguarding Practice Review (LCSPR) was unnecessary as the appropriate learning had been extracted though the process. After communication with the National Panel, it was agreed that a LCSPR would be undertaken in the form of the recommended case audit.

4.0 The Case Audit

4.1 The terms of reference for the Local Safeguarding Practice Review which was to be conducted in the form of an audit are: -

- To examine the effectiveness of inter-agency working and service provision in relation to the identification and response to concerns about child sexual abuse.
- To examine the quality and impact of the initial response, assessment, interventions, planning and decision-making in response to concerns, notifications and referrals.
- To be assured the right agencies are in attendance at decision-making forums/meetings and practitioners are using professional curiosity and challenging decisions where appropriate.
- Determine whether decisions and actions comply with the policy and procedures of named services and the CSCP.
- Consideration of sexual abuse, in the absence of a disclosure, when presented with injuries consistent with physical abuse/non-accidental injury.
- To be assured practitioners are aware of their roles and responsibilities and understand operational procedures, protocols and referral pathways.
- Timeliness and effectiveness of communication and information sharing between key agencies/professionals in the management of cases of sexual abuse.
- Reflect on what is learnt about local practice and identify opportunities to develop practice and improve safeguarding arrangements.

4.2 The audit identified 10 children who were under 5 years of age and all agencies involved in the cases were asked to complete an audit template that was designed for agencies to consider key areas corresponding to the key lines of enquiry. These areas were (full criteria at appendix A): -

- Identification and recognition of sexual abuse
- Strategy meetings
- Case management
- Sexual Assault Referral Centre (SARC)
- Coordination between agencies and information sharing

- Voice of the child

Each agency was asked to consider each of the criteria in terms of what worked well, what did not work so well and what should happen as a result. The case audit was followed up by multi agency meeting to discuss, challenge and moderate the audit returns. Where agencies identified areas of development within their own organisation, as with any audit activity it was incumbent on them to raise and address these issues.

4.3 Each of the key areas of consideration will be commented on.

4.3.1 Identification and recognition of sexual abuse

Most of the cases analysed in the audit had been referred on the basis of a concern regarding sexual abuse so the recognition and identification was evident. There was one case that was strikingly similar to the T case.

This case occurred in August 2021 when a child was admitted to hospital with 74 bruises some to genital area and bottom.

There was a child protection medical at the hospital and an initial strategy meeting with Emergency Duty Team (EDT). There was no initial consideration by police, children services or health of the potential of sexual abuse. This was set against a background of agencies previously being involved with the family and a concern regarding a person with connections to child sexual abuse being associated with the family. The SARC was not informed and was not invited to the initial or subsequent strategy meetings. This delayed the SARC examination which did not take place until 7 days after the child's initial presentation at hospital.

4.3.2 Strategy meetings

Of the 10 cases analysed it was identified and agreed appropriate that three cases did not meet the requirement for a strategy discussion.

Of the seven remaining cases, four had a strategy discussion and in three cases a strategy discussion did not take place, where it would have been appropriate. In one of these cases a discussion did take place regarding the case when a further referral was made and was recorded on that referral.

In the cases where strategy cases should have taken place, but did not, there was some evidence of inter-agency discussion (not a strategy discussion), and in some cases, action coming from these discussions.

In none of the cases where strategy discussions/meetings took place was Mountain Healthcare considered or invited. This included three cases where a sexual abuse medical took place. In these cases, Mountain Healthcare was only spoken to after the strategy discussions had taken place.

Similar to the T case, there was evidence that a strategy meeting should have been reconvened when further information or medical results were received but this did not occur.

Where strategy discussions did take place, Mountain Healthcare aside, the core agency attendance was good but there was limited evidence of education or health visiting being considered. This was then reflected in the feedback of information to agencies, including the strategy meeting minutes. In one case the GP was the referrer of the case but did not receive any feedback on how the case was progressed.

Where strategy discussions/meetings did not take place there tended to be a lack of clarity and coordination in the progression of the case.

4.3.3 Case management

The case management was variable according to the agencies involved and the level of their involvement. There was some evidence of a lack of recording of management oversight and of the rationale for some significant decisions. Where management actions were set on occasions, they were not SMART and did not lead to the required outcome.

The audit information returned by the Clinical Commissioning Group (CCG) on behalf of GP's identified that there was a lack of sexual abuse marker put on the records of relevant cases. One of the potential risks regarding this is the history would not be immediately apparent should the child be presented in a health setting such as the out of hours service.

4.3.4 Sexual Assault Referral Centre (SARC)

In none of the three relevant cases was the SARC notified or consulted in a timely way. The SARC was not invited to any of the initial strategy discussions. The relevant cases indicated that there was confusion over the process of achieving a SARC medical and these factors led to delays in relevant SARC examinations taking place.

4.3.5 Coordination between agencies and information sharing

There are some good examples of information being shared and joint action being taken by agencies. What was missing from this activity was overall coordination and follow up of actions and this can be attributed to the lack of an early and robust strategy discussion/meeting.

An area that was discussed and agreed in the audit panel meeting was the necessity to use accurate and universally understood language in recording. An example of this is the term 'private parts' being used instead of a specific body term. This could lead to confusion and incorrect interpretation.

4.3.6 Voice of the child

Agencies could demonstrate good examples of where the child's voice and lived experience was sought and this was well recorded, but this was not consistent. The cohort for this review was children aged 5 and under and it was noticeable that the evidence of the child's voice being present was stronger in the children in the elder section of this cohort. It was also noticeable that when dealing with the critical elements of a case the recording of the voice of the child was stronger. It tended to be not so evident when the contacts became more routine.

4.3.7 In the audit discussion where individual agencies identified areas of development for their own agencies these areas were highlighted and addressed within that organisation.

5.0 Discussion

5.1 This discussion will make reference to the three elements of this review, the rapid review, Family Court Fact Finding and the case audit to identify and draw together the learning.

5.2 Identification and recognition of sexual abuse

5.2.1 T was presented to the hospital, he was examined initially by a junior doctor who felt that T's injuries could be non-accidental. The doctor referred T to a paediatric registrar who after examination mapped 22 injuries to T's body, including red-blue bruising around the whole penis including the underside and extending to the scrotum just below the penis and circumferential redness around the anus. In giving evidence to the Family Court the registrar stated that in a six-year paediatric career, they had never seen this degree of bruising in a child of T's age.

5.2.2 The next day, following hospital admission T was reviewed by the consultant paediatrician. The paediatrician noted the injuries mapped by their colleague and noted a further 20 marks on T. Again, when giving evidence this consultant remarked that the injuries recorded on T were the worst they had seen.

5.2.3 A strategy discussion was convened, and the minutes reflect that T has '*really significant bruising to his genitals'*. The mother had given an explanation of nappy rash and the doctor attending the strategy meeting described this explanation as plausible. The strategy meeting recorded that the threshold of significant harm was met and there would be a joint section 47[4] investigation under the category of physical abuse. At this stage no consideration was given to the possibility of sexual abuse.

5.2.4 Three days after T's initial presentation at hospital the consultant paediatrician reviewed the case and liaised with the designated doctor[5], an experienced child sexual abuse examiner. It was at this stage that it was discussed that there should be a sexual abuse medical. Up until this point there had been no interaction with the Sexual Assault Referral Centre (SARC), where such a medical would be undertaken.

5.2.5 In the Family Court judgement the judge made the following comment when considering the timeliness of the recognition of the potential of sexual abuse.

'Having viewed the photographs taken on the afternoon of 22 July 2020, the failure by the treating clinicians to appreciate that T's genital injuries and the extensive anal redness might be indicative of a serious sexual assault warranting an urgent forensic examination seems utterly inexplicable.'

5.2.6 There was a lack of recognition of the potential sexual abuse in this case, which occurred in July 2020 and physical abuse was the initial focus. A similar situation was seen in one of the audit cases, which occurred in August 2021. This case also involved a young

[4] Section 47, Children's Act 1989 - where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare.

[5] Clinical commissioning groups should employ, or have in place, a contractual agreement to secure the expertise of designated practitioners, such as dedicated designated doctors and nurses for safeguarding children and dedicated designated doctors and nurses for looked-after children. Working Together 2018, HMG.

child with very significant multiple injuries, with some of those to the genital area. In this and the T case there was an initial failure to consider sexual abuse in the context of significant physical abuse. The Judge in the fact finding cites the Guidance published by the Royal College of Paediatrics and Child Health[6].

'The guidance contains a chapter on the genital signs of sexual abuse in boys. Its review of the literature indicated that, although not well reported, genital injuries, predominantly to the penis, occur in a small proportion of boys who have been sexually abused. It identified a number of issues for clinical practice, and I highlight the most relevant to T's case, namely that, when a boy presents with a genital injury and there is an absence of a supportive history of an accident, or if the history for the injury is inconsistent with the explanation, child sexual abuse should be considered (page 125). Anogenital injury without an acceptable explanation is an indicator for a referral for a forensic examination (paragraph 11.2.9, page 220). I note that the Purple Book is also clear that clinical signs of trauma heal rapidly and may be lost unless a child is examined within 24 hours of the alleged assault though evidence may still be present up to 72 hours and even up to one week after the alleged assault in older children (paragraph 11.3.13, page 226).'

5.2.7 The purple book gives clinicians guidance on good practice and states that as part of a holistic assessment children presenting with concerns about physical abuse, neglect or emotional harm should also have an inspection of the genitalia and anus with appropriate consent.[7]

5.2.8 There is a subsequent lack of recognition of the potential of sexual abuse by the wider professional group in the strategy discussion. This is a group of predominantly specialist professionals in their respective fields. The strategy discussion/meeting (discussed in more detail at section 5.3 below) should allow professionals the opportunity to appropriately test and challenge the information being discussed and to discuss and test various hypothesises.

5.2.9 At the initial strategy discussion the account given by the mother that T had suffered diarrhoea as an explanation for the redness around T's anus. The minutes reflect that the clinician considered this as a plausible explanation. There is no evidence of any challenge to this view. In February 2020, the joint inspectorate published the finding of a Joint Thematic Area Inspection (JTAI) into sexual abuse.[8] The inspection recognised that professionals found this area of practice very difficult. The report recognised that there was often a lack of effective challenge between agencies when discussing information.
In 2020 the NSPCC published a briefing on the learning from serious case reviews published since 2017[9]. The guidance found that one key area was the early identification of sexual abuse and stated, '*Professionals are not always equipped to identify potential signs of sexual abuse. They may overlook physical and behavioural indicators due to a focus on alternative explanations from parents and carers or health professionals.'*

[6] & 7 The Physical Signs of Child Sexual Abuse: An Evidence-Based Review and Guidance for Best Practice, May 2015, Royal College of Paediatrics and Child Health.

[8] Multi Agency Response to sexual abuse in the family environment :Joint Area Thematic Inspections (JTAI), February 2020, HMG
[9] Child sexual abuse: learning from case reviews, January 2020, NSPCC

5.2.10 Practitioners, particularly those involved in the specialist area of child protection and safeguarding need to be alive to the consideration of poly victimisation. Children who have experienced one type of abuse are more likely to have suffered another category of abuse. Children who are physically abused are six times more likely to have been sexually abused. The triennial review of serious case reviews 2011- 2014 reviewed 293 serious case reviews, one of the findings on sexual abuse was that sexual abuse often co-existed with other types of harm; there was evidence of sexual abuse in 53% of cases relating to children who were at least one year of age[10].

5.2.11 The Coventry Safeguarding Children Partnership published a three-year Child Abuse Strategy under three themes of Prevention, Protection and Support. The strategy recognises that sexual abuse is often initially presented as another form of abuse. The strategy includes developing a sexual abuse policy, developing a network of CSA champions, reviewing the workforce development offer and developing a directory of resources.

5.2.12 There needs to be a better understanding of what the barriers are for professionals to be considering the potential of sexual abuse. If the potential is not being considered in specialist environments there is little chance that it will be considered or identified in more routine environments. Within safeguarding the phrase ‘think the unthinkable’ has existed for some years, dating back to reviews in 2013 but it still seems that professionals have a difficulty in considering the potential of sexual abuse.

5.2.13 The hospital trust has, since the T case, undertaken training with relevant hospital staff. This is being delivered on a priority basis. The designated doctor for the partnership has developed a seven-minute briefing on child sexual abuse for paediatricians, emergency doctors and other health staff. The panel has agreed that there would be great benefit in involving Mountain Healthcare in any relevant training and this was welcomed by Mountain Healthcare.

Learning: - In the T case there was a lack of recognition or consideration of the potential of sexual abuse. This ran through the initial medical examinations and initial multi agency discussions. This led to further problems regarding the processes that should have flowed from the early identification and discussion. Similar issues were witnessed in a case within the case audit. There is a current focus on child sexual abuse within the partnership with the most recent annual report indicating that a webinar (which is available on the partnership website) attracted the largest audience. These cases would indicate that there needs to be more work on raising the awareness of the potential sexual abuse and understanding what the barriers to this might be.

Recommendation 1

The Coventry Safeguarding Children Partnership should consider how the partners can build on the Child Abuse Strategy to understand what the barriers are in professionals considering the potential of sexual abuse in the family environment.

[10] Sidebotham, P et al., (2016), Pathways to harm; pathways to protection; a triennial analysis of serious case reviews 2011-2104 DfE

Recommendation 2

The University Hospital Coventry & Warwickshire Trust should: -

- Review what training on child sexual abuse is delivered to clinicians who examine children.
- Ensure that staff are aware of the need to access specialist safeguarding advice and how this can be achieved.

Recommendation 3

All agencies involved in this review should use the circumstances of this case, family court fact finding and the associated case audit to ensure that staff who are likely to be involved in strategy discussions and meetings consider the potential of sexual abuse.

Recommendation 4

Where agencies are undertaking training on child sexual abuse there should be consideration of involving Mountain Healthcare to enhance the understanding of the referral pathway and further develop inter-agency relationships.

5.3. Strategy discussions/meetings

5.3.1 Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case[11].

5.3.2 In this case the strategy meeting took place the day following T's presentation. The meeting was attended by CSC, police, and the consultant paediatrician. Health information was shared by the health visitor with the social worker over the phone. At this time T had been examined by three separate clinicians and significant injuries noted. The strategy meeting was informed by the paediatrician that T had bruising to the following areas: 'forehead, chin, arms, forearms, chest, left flank, groin, suprapubic areas on both sides, penis, scrotum, areas around the genital area, legs on both sides, the knees, calves, lower back, neck, posterior aspects of the arms and forearms, the buttocks and posterior aspects of the right leg and calf'[12].In addition T is described by consultant paediatrician as having "really significant bruising" to his genitals. When asked about the redness to T's anus the paediatrician stated that the mother's explanation was that this was due to diarrhoea and the paediatrician regarded this to be a plausible explanation.

[11] Working Together 2018, HMG
[12] Strategy minutes

5.3.3 With the knowledge of the nature of the genital injuries and other bruising prior to the strategy meeting sexual abuse should have been considered and if there had been any doubt the appropriate professionals invited to the strategy meeting to share their experience and opinion (designated doctor). There should also have been consideration at this stage of involving the SARC in the strategy meeting.

A professional may need to be included in the strategy meeting/discussion who is not involved with the child, but who can contribute expertise relevant to the particular form of abuse or neglect in the case[13]

It was a theme in the audit of cases for this review that the SARC was consistently not invited to strategy discussions where it was apparent that sexual abuse was going to be discussed and a medical examination planned. It might assist if the regional guidance was more explicit around child sexual abuse and the need to invite the health provider delivering the SARC services for the area. The health provider, Mountain Healthcare have a dedicated Safeguarding and Strategy manager.

5.3.4 The case audit identified that strategy meetings were not undertaken in three cases where the criteria were met for one to take place. It was the view of the review panel that a strategy discussion/meeting should be considered in all cases of child sexual abuse.

5.3.5 In the T case there was a further review of the medical finding post the strategy meeting, two days after T's initial presentation. T's case was reviewed by one of the hospital child protection leads. The paediatrician reviewed the notes and examined T on the ward and noted '*bruising very concerning - no reasonable explanation - does not fit with accidental trauma; concentration of bruises around genitals was worrying; anal bruising with crescentic redness - sexual abuse unlikely, but in view of presentation, required consideration'.* The paediatrician discussed the case with the designated doctor, and it was agreed that T required a specialist sexual abuse medical examination that would take place at the SARC. The paediatrician contacted the social worker and informed them of the concerns and that a medical at the SARC should be arranged. There then followed some confusion over the arrangements for the medical which will be discussed in the next section.

5.3.6 The consideration of sexual abuse, albeit late was effectively new information in this case which needed to be discussed, this should have resulted in a fresh strategy meeting to discuss the concerns over the sexual abuse with the right professionals present in order that a plan of action could be formulated and coordinated. This did not take place, and this contributed to the confusion that ensued. During the reflective event for this case, it became apparent that the police were not notified of the consideration of sexual abuse until one week after T's initial presentation and 4 days after the discussions between health professionals and CSC. This is less than ideal for many reasons but a considerable one being the police had arrested T's mother and her partner some 6 days previously.

[13] Regional Child Protection Procedures for West Midlands

'A strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case.'[14]

5.3.7 If professionals had more of an awareness of the prevalence of child sexual abuse in relation to indicators of physical abuse they would be better equipped to discuss and appropriately challenge to allow at least the hypothesis of sexual abuse, even if it is relatively quickly dismissed from the information and evidence available. Research from Centre of Expertise for Child Sexual Abuse shows that when children are examined within seven days of an episode of CSA, studies report that 11% to 52% are found to have an injury outside the anogenital area, which may support an account of CSA or be a medical need in itself[15].

Learning:- Strategy discussions/meetings provide the multi-agency foundation for coordination of enquiries where a child is suffering or likely to suffer significant harm. The case audit and the T case provide examples of how, without this foundation, important considerations are missed, which can lead to missed opportunities to gather information to protect a child. The importance of a robust, appropriately attended and informed strategy discussion cannot be overstated. This is highlighted in the National Review into Child Protection, where the two reviewed cases both suffered from the lack of an appropriately convened and attended strategy discussions.[16] In child sexual abuse cases it is important that the SARC attends the meeting.

Where there are unexplained anogenital injuries the ensuing strategy meetings must include the SARC. The SARC can be consulted by any professional, however a referral must be in line with local safeguarding procedures.

The case audit showed some good practice of schools being invited but this was not consistent. GPs were not routinely invited to strategy meetings, and this included an example where they had referred the case.

Recommendation 5

The Coventry Safeguarding Children Partnership should ensure that strategy discussions are being undertaken in relevant cases. This should include –

- Ensuring that the right professionals attend discussions/meetings, in child sexual abuse cases including the SARC.
- That where there is new information that requires sharing and discussion a further strategy meeting is convened.

[14] Working Together 2018, HMG
[15] The role and scope of medical examinations when there are concerns about child sexual abuse A scoping review 2019, Cutland M, Centre of Expertise on child sexual abuse
[16] The Child Safeguarding Practice Review Panel,2022, Child Protection in England – National Review into the murders of Arthur Labinjo-Hughes and Star Hobson

Recommendation 6

The Coventry Safeguarding Children Partnership should consider working with regional partners to include in the regional guidance on SARCS being invited to all sexual abuse strategy meetings.

5.4 Coordination of Child Protection and Child Sexual Abuse medical examinations.

5.4.1 In the T case a child protection medical assessment was undertaken on the morning following T's presentation in hospital. The assessment was undertaken by a paediatric consultant. The safeguarding procedures state that the purpose of a medical assessment is to ascertain whether there is any medical evidence to support the existence or extent of abuse or other serious health needs and, if necessary, to treat the child. A medical assessment should demonstrate a holistic approach to the child and assess the child's well-being, including mental health, development and cognitive ability. The examining doctor should provide a report to the social worker, the GP and where appropriate, the police.[17]

5.4.2 As already discussed the potential of sexual abuse was not recognised at an early stage and this factor prevented consideration of a medical assessment which could have encompassed a sexual abuse medical as a joint examination. Guidance describes a medical for child sexual abuse as '*a comprehensive assessment considering the physical development and emotional well-being of the child or young person against the background of any relevant medical, family or social history … This enables a full evaluation of the degree of significant harm suffered, or likely to be suffered by the child … Evaluating significant harm in sexual abuse includes not only the documentation of any genital and or anal injury but also any accompanying physical injury, the possibility of a sexually transmitted infection or pregnancy and the short/long term psychological or psychiatric sequelae. This assessment must also lead the planning of any ongoing investigation or treatment required by the child and appropriate reassurance for the child and family."*[18]

5.4.3 The Mountain Healthcare providing services for the SARC and the commissioner of these services, NHS England, agree that joint examinations are preferable. There are a number of reasons for this but one of the most important is that it puts the child or young person's welfare at the centre and may prevent them from undergoing more than one examination. A key to the consideration and coordination of joint examinations is an early and appropriately attended strategy discussion/meeting as already discussed.

5.4.4 In the T case, once sexual abuse became a consideration, and it was established that a sexual abuse medical was required, there was confusion over how this should be achieved, and this confusion led to a delay in the examination. The same was true of the similar case within the case audit. Both cases resulted in a SARC examination not taking place until one week after the child's initial presentation.

[17] Regional Child Protection Procedures for the West Midlands

[18] Royal College of Paediatrics and Child Health/ Faculty of Forensic and Legal Medicine (2012) Guidelines on Paediatric Medical Examinations in Relation to Possible Child Sexual Abuse. London: FFLM.

5.4.5 In the T case the consideration of sexual abuse occurred on a Friday and there was a conversation between the safeguarding paediatrician and the social worker. There was a mistaken belief that the SARC was not operational for child sexual abuse medicals over the weekend period. As a result, the medical was not arranged until the following week and did not take place until the Wednesday of that week.

5.4.6 The sexual abuse medical at the SARC was not a forensic medical as the examination was outside of the recognised timeframe for the recovery of forensic samples. The medical was undertaken by a forensic examiner who was qualified in accordance with the standards as set out by relevant guidance.[19] It is not clear how much information from the previous hospital examinations or what the level of liaison was between the hospital clinicians and the SARC examiner. It would be important for the SARC examiner to at least be sighted on the previous examinations and what had previously been recorded. The SARC examination was recorded, with the use of specialist examination equipment.[20]

5.4.7 The examination noted a number of injuries to the body and included two injuries and redness to the anal area. The examination findings did not confirm or refute any disclosure of sexual assault. The paediatrician noted that the timing of an examination was crucial and that a child should be seen as soon after an assault as possible as anogenital injuries were known to heal very rapidly and often completely, leaving no trace of trauma. If a sexual assault resulting in injuries had occurred, they noted that these may well have healed completely before his examination took place.

5.4.8 Fifteen days later the designated doctor undertook a health assessment as T was a looked after child (and had been since the mother's arrest). The examination recorded anal laceration and scarring. One of these scars the designated doctor formed the view that it was suggestive of sexual abuse in the absence of a history of exceptional trauma such as anal impalement. The most likely explanation was that the laceration was sustained shortly before T's initial hospital presentation and had undertaken a degree of healing. The day prior to this examination T had attended the SARC for a follow up visit to undertake screening for sexual transmitted infections. The same clinician undertook this examination who had previously examined T at the SARC. At this follow up appointment there was no re-examination of T's anogenital area.

5.4.9 The designated doctor stated for this review and the family fact finding that T should have been medically stabilised and should have had an examination within 24 hours of the concern being noted. A consultant paediatrician commissioned for the fact finding to comment on the case concluded that '*the possibility of sexual assault should have been excluded a great deal earlier following T's presentation to hospital*.'

5.4.10 The Judge in the fact finding commented on the process of achieving a child abuse medical examination: -

'*If it is correct that there is no formal protocol between the SARC and the police / the local authority / hospitals, that strikes me as a significant deficit which should be rectified swiftly in*

[19] Royal College of Paediatrics and Child Health/ Faculty of Forensic and Legal Medicine (2021) Quality Standards for clinicians undertaking Paediatric Sexual Offence Medicine (PSOM)
London: FFLM.

[20] An instrument with a magnifying lens and a light, called a colposcope. It magnifies the image many times. The healthcare provider sees the tissues on the cervix and vaginal walls more clearly.

order that it is clear who has what responsibility to refer for a specialist examination, and the timescales for achieving the same.'

The fact finding was presented evidence from the Local Authority that the sexual abuse and abuse strategy coordinator for the area (a post funded by the NHS, involving partnership with the Local Authority) had indicated that they were "*currently working on a flowchart for all the different ages in SARC and what the timescales are for forensics so every service in [area] does not make the mistakes of missing those windows"* .It is apparent that this guidance does exist but the issue is ensuring that relevant practitioners are aware of it.

5.4.11 Discussion with Mountain Healthcare and the commissioners of the service establish that there has been communication to agencies on the functioning of the SARC and how the service should be accessed. The T case and subsequent case audit would indicate that it is still not embedded and there remains some confusion. The reasons why the information may not be embedded with practitioners was discussed and there was a view that a high turnover of key staff may result in key messages not being sustained. In another area where Mountain Healthcare provides the SARC service there is a protocol between SARC, police and commissioners on how the service will be delivered for acute and non -acute services.

5.4.12 There are a number of strategic groups that have oversight over the governance of the SARC and delivery of the service. There is not currently an operational group. Prior to the covid pandemic there was a Partnership Group, constituted of SARC, police, health and the Local Authority. This group would meet and discuss the functioning of the SARC and build on the partner relationships. It is the intention of the commissioners to re-establish this group and this review feels that there would be real benefit in this.

Learning: - There is confusion amongst practitioners regarding the accessing and coordination of medicals for child sexual abuse. A reason for this may be due to the turnover of key staff. There needs to be a concerted awareness raising for staff and this should be supported by a relevant policy and guidance for staff. The lead for this area of work and the monitoring of impact could sit with the SARC partnership group to be established. Where a child is taken to the SARC for medical it is important that the records of previous examinations are presented to the examining clinician, including body maps and that these are able to be retained in SARC records. Where a child attends the SARC for a follow up visit it is important that consideration is given, where clinically and evidentially appropriate, to re-examine the child for any signs of sexual abuse.

Recommendation 7

Agencies involved in referring children to the SARC for examination should ensure that full relevant records of previous examinations (including body maps) are made available to the SARC to fully inform the examination and that they are available for retention with the SARC records.

Recommendation 8

Where a child is examined at the SARC, including follow up visits, on each occasion consideration should be given to examine the child for any signs or indications of sexual abuse where clinically and evidentially appropriate and with appropriate consent.

Recommendation 9

NHS England, the commissioners of the SARC service should seek to re-establish the SARC Partnership Group. This group should include key stakeholders and undertake a role to raise the awareness of the operation of the SARC and monitor the embedding of awareness.

Recommendation 10

The partners of the Coventry Safeguarding Partnership should agree a policy on undertaking child sexual abuse medicals in the SARC. This should be accompanied by easy-to-follow guidance for staff.

Recommendation 11

The Coventry Safeguarding Children Partnership should work with constituent members to understand how the turnover of key staff may be impacting on key local information being lost and how this can be addressed in relevant staff induction.

5.5 Voice of the child

5.5.1 The case audit presented the opportunity to consider how effectively the voices of children and their lived experience was being reflected in cases. There were some good examples noted of where this was happening, but it could not be said to be consistent, and it remains an area that could be further developed. There was evidence that the views of the children were being sought through conversations with parents instead of seeking ways to interact with the child such as through observations of behaviours, attachments, play and sound. On occasions there was recording of the child's voice being sought but there was a lack of recorded reflection on what was being said or what reassurance given.

'Hearing the voice of the child' requires safe and trusting environments for children to be seen individually, speak freely, and be listened to'[21]

5.5.2 The audited cases tended to reflect good recording and evidence where the practitioners were responding to a particular incident or concern, but the same level of recording and reflection was not present in what may be more routine engagements. Where there were a number of recordings over a period of time there was a tendency for recordings to be the same and did not show progression, changes in circumstances or development. This tendency was also identified in a briefing submitted to Coventry City Council Education and Children Services Scrutiny Board in November 2021. The same briefing also recognised a lack of recording where children were too young to voice their own concerns.

Recommendation 12

The Coventry Safeguarding Children Partnership should consider what information is available to practitioners to effectively seek and record the voice of the child and lived experience, in particular in young pre-verbal children. The partnership should consider what good practice there is available to draw on.

[21] Sidebotham, P et al., (2016), Pathways to harm; pathways to protection; a triennial analysis of serious case reviews 2011-2104 DfE

5.6 Commissioning of the Local Safeguarding Practice Review

5.6.1 Initially the T case was not considered for a safeguarding review and no rapid review meeting took place until 15 months after T had presented in hospital. This raises the question how learning opportunities are identified within the agencies and how these are raised with the Partnership. The rapid review and safeguarding review were only considered after it had been discussed as part of the Family Court hearing. This said there is evidence that the rapid review once convened was thorough and recommended the case audit. The Safeguarding Partnership needs to be sure that it has the right mechanisms in place to identify cases of concern where there may be learning from.

Recommendation 13

The Coventry Safeguarding Children Partnership should ensure that there are robust mechanisms in place to identify cases which will present learning and development opportunities.

6.0 Recommendations:

Recommendation 1

The Coventry Safeguarding Children Partnership should consider how the partners can build on the Child Abuse Strategy to understand what the barriers are in professionals considering the potential of sexual abuse in the family environment.

Recommendation 2

The University Hospital Coventry & Warwickshire Trust should:-

- Review what training on child sexual abuse is delivered to clinicians who examine children.
- Ensure that staff are aware of the need to access specialist safeguarding advice and how this can be achieved.

Recommendation 3

All agencies involved in this review should use the circumstances of this case, family court fact finding and the associated case audit to ensure that staff who are likely to be involved in strategy discussions and meetings consider the potential of sexual abuse.

Recommendation 4

Where agencies are undertaking training on child sexual abuse there should be consideration of involving Mountain Healthcare to enhance the understanding of the referral pathway and further develop inter-agency relationships.

Recommendation 5

The Coventry Safeguarding Children Partnership should ensure that strategy discussions are being undertaken in relevant cases. This should include –

- Ensuring that the right professionals attend discussions/meetings, in child sexual abuse cases including the SARC.
- That where there is new information that requires sharing and discussion a further strategy meeting is convened.

Recommendation 6

The Coventry Safeguarding Children Partnership should consider working with regional partners to include in the regional guidance on SARCS being invited to all sexual abuse strategy meetings.

Recommendation 7

Agencies involved in referring children to the SARC for examination should ensure that full relevant records of previous examinations (including body maps) are made available to the SARC to fully inform the examination and that they are available for retention with the SARC records.

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Appendix A – Terms of Reference

Coventry Safeguarding Children PARTNERSHIP

Child T Safeguarding Practice Review
Terms of Reference

- To examine the effectiveness of inter-agency working and service provision in relation to the identification and response to concerns about child sexual abuse
- To examine the quality and impact of the initial response, assessment, interventions, planning and decision-making in response to concerns, notifications and referrals
- To be assured the right agencies are in attendance at decision-making forums/meetings and practitioners are using professional curiosity and challenging decisions where appropriate
- Determine whether decisions and actions comply with the policy and procedures of named services and the CSCP
- Consideration of sexual abuse, in the absence of a disclosure, when presented with injuries consistent with physical abuse/non-accidental injury
- To be assured practitioners are aware of their roles and responsibilities and understand operational procedures, protocols and referral pathways
- Timeliness and effectiveness of communication and information sharing between key agencies/professionals in the management of cases of sexual abuse
- Reflect on what is learnt about local practice and identify opportunities to develop practice and improve safeguarding arrangements