City of York
Safeguarding Children Partnership

7 Point Briefing:
Harmful Sexual Behaviour Audit

Background

The City of York Safeguarding Children Partnership (CYSCP) commissioned an audit undertaken by NSPCC to establish improvements and good practice, but also to identify potential gaps in multi-agency working when working with young people who display harmful sexual behaviour (HSB) within the City of York.

A multi-agency task group was established to consider the framework of HSB and significantly improve the offer available from April 2020. In June 2023, a multi-agency audit was undertaken to identify if the work carried out by the HSB Task Group had impacted upon practice. The focus of the audit included:

- Prevention
- Initial response
- Assessment
- Impact on the child

What areas of good practice was highlighted?

The audit highlighted many areas of good practice and communication between services. It is apparent that the service provision for young people displaying HSB has improved, with the City of York focusing on prevention alongside statutory offences.

There was clear evidence that preventative work is being undertaken, through referral to the Youth Justice Service and other agencies to complete intervention once concerns were raised. Cases mainly highlighted good multi-agency working and communication.

The audit evidenced there was a high level of support for parents for all the children being considered by different services. Where appropriate, interventions were offered and delivered to parents.

The Youth Justice Service offer specific HSB assessment for both preventative and statutory cases, using research from the NSPCC and AIM project. AIM3 is available for those aged 10-18 years old, AIM3 Under 12's is available for those aged between 10 and 12 years old, AIM digital technology assessment is also available.

When considering the support for families, it was apparent that agencies work well together, which is evidenced in case records and shows clear communication with the families throughout.

Key Learning Points

Learning Point 1

It is imperative that a clear definition of HSB is understood by all agencies. The audit highlighted that confusion could occur when a young person is both a victim and perpetrator of HSB, which can lead to inconsistent intervention and offers of service provision. To address this, the HSB multi-agency training offer includes a clear definition of HSB and addresses potential dilemmas.

Learning Point 2

The audit highlighted the necessity to ensure opportunities to engage early with children and families must not be missed and referrals need to happen at the time that concerns are highlighted. Circumstances such as changes of keyworkers or long term staff sickness must considered and families re-allocated at the soonest opportunity.

Learning Point 3

Though online safety is mandatory within schools during Relationships, Sex and Health Education (RSHE), consideration must be given to those children with low levels of attendance and ensuring they receive these lessons. In addition to this, some young people have experienced gaps in their education provision due to the Covid 19 pandemic, which may have reduced their access to some of this important education and preventative work.

Learning Point 4

Non statutory cases of HSB rely on engagement and consent to work with services from the child and parents. When working with families experiencing HSB, there is a need to consider and address feelings of shame, disbelief, and a possible mistrust of agencies. Engagement from parents is increased when there is a stable and consistent team supporting the family.

Learning Point 5

Unsupervised internet use within the family home can be significantly problematic. The internet is accessible through many devices within the average household, including mobile phones and can be difficult to manage from a parent's perspective. There is a necessity to ensure that internet use is addressed, and advice given to parents, such as parental controls and methods of monitoring.

Learning Point 6

Communication between services that are working with HSB is paramount. Information sharing must be concise, timely and available to partners working with the family. This includes ensuring partners are invited to meetings and if unavailable, updates must be provided.

Learning Point 7

Police investigations relating to HSB can be lengthy, therefore support is required for the family during this time. There is a need to ensure that partners share requested information with the police at the soonest opportunity to avoid further delay.

Key Recommendations

- Ensure that all agencies have awareness of young people displaying harmful sexual behaviours, through NSPCC training and resources such as the CYSCP website.
- Ensure outcomes of meetings relating to behaviours and risk are shared across all agencies, such as information from strategy meetings.
- Offer support in long term police investigations where appropriate.
- Ensure the voice of the child is apparent in all cases at all times.
- Where children have missed significant periods of schooling, ensure they receive support with RSE subjects.

Next Steps

- Each individual single agency will disseminate the learning within their organisations.
- A multi-agency action plan has been produced and monitored by the partnership.

Useful resources and further reading

CYSCP Harmful Sexual Behaviour Procedure

CYSCP Harmful Sexual Behaviour One Minute Guide

CYSCP Harmful Sexual Behaviour Presentation

CYSCP Harmful Sexual Behaviour webpage

CYSCP Online Safety webpage

'Developing an Understanding of Harmful Sexual Behaviour' Training

Where do I go for further information?

Please visit the **CYSCP website** for up to date information and latest news.

Please also sign up to the **CYSCP Newsletter** and follow us on Twitter **@YorkSCP**