



**Mabel**  
**Child Safeguarding Practice Review**

**Lead Reviewers: Kelly Dudding and Lucy Cook**

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## 1. Introduction

### 1.1 Why was this case chosen to be the focus of the review?

- 1.1.1 Working Together 2018 requires the Local Safeguarding Children's Partnership (LSCP) to make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases where they consider it appropriate for a review to be undertaken.
- 1.1.2 Serious child safeguarding cases are those in which: abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed. When a serious incident becomes known to the safeguarding partner, they must consider whether the case meets the criteria for a local review and determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements in practice. There is a requirement to undertake a rapid review of the case to consider the potential of the case for identifying improvements to safeguard and promote the welfare of children.
- 1.1.3 The Governance meeting acknowledge that the threshold for a Local Children's Safeguarding Practice Review (LCSPR) was met for this case as Mabel has suffered significant emotional harm and trauma. There is an opportunity to explore further information during the LCSPR, such as the outcome of any mental health assessment for Mabel, and the effectiveness of interventions such as Barnardo's, CAMHS, and children's social care. In addition, consideration of whether there had been adequate professional escalation and challenge during and following child protection procedures throughout. There is an opportunity for the review to provide both local and national learning points.

### 1.2 Succinct summary of the case

Mabel is 15 years of age and has been known by several different names, when she was approximately 11 years old Mabel began to identify as male and throughout the next few years of Mabel's life her gender identity would alter between male and female. However, she now prefers Mabel and identifies as female.

Police attended Mabel's family home in July 25 after they were notified by the National Crime Agency that Mabel had been uploading indecent images of herself to the internet. During the Police visit, Mabel made disclosures of sexual harm to the attending Police Officers. Mabel disclosed 'being in a sexual relationship' with an adult male for the past year. Mabel stated that the male was 30 years old and that she had recently discovered that he was a person working in a position of trust.

There also significant concerns about Mabel's mental health and emotional well-being; she has taken overdoses and made suicide attempts.

Mabel was sexually assaulted by a family member when she was approximately 6/7 years old. She has had significant input from CAMHS and has been subject to Child in Need Plans and subject to an ICPC, where the decision was made to continue support as Child in Need though the risk of exploitation recognised.

## **2. The Terms of Reference**

### **2.1 Involvement of the child and family**

- 2.1.1 Following receipt of the merged chronology the reviewers met with Mabel, her mother and stepfather to enable them to share their experiences of interventions and support offered to her throughout her childhood.
- 2.1.2 A further meeting took place prior to publication to share findings and explain the publication process.

### **2.2 Which areas of learning can this case help us understand about how the safeguarding system is functioning?**

- 2.2.1 The Executive considered the content of discussion in the Rapid Review and wider system issues and identified the following key lines of enquiry for the review to consider:
- How do professionals work with parents / carers where there are concerns regarding CSE and online grooming?
  - What is our collective understanding of threshold identification of children's needs/ signs of CSE and when to refer for further support for CSE?
  - What does effective intervention look like?
  - What is best practice in information-sharing and professional challenge in the context of this case?
- 2.2.2 Discussion was undertaken with the Executive committee following reviewers meeting with Mabel and her mother and stepfather and also, consideration of the merged chronology to finalise the questions and areas to explore. The questions were adapted slightly to ensure that effectiveness of the systems around Mabel were fully explored, and learning could be determined to inform future practice.
- 2.2.3 The final key lines of enquiry for the review to consider were agreed as:
- How does the system support shared understanding of early childhood trauma when considering presenting risks later in a child's life around their mental health, emotional wellbeing and emerging risks of sexual exploitation and grooming? How do we support parents and children to understand the impact of trauma on future risk and vulnerability?
  - What does effective intervention look like – more specifically how do we ensure families understand who is supporting and why, and what support looks like moving forward when services retract support or are unable to support.
  - It is recognised that the approach to Harm Outside the Home (HOTH) within Tees has progressed significantly in recent years. How can we reflect on this progress, and do we consider the response to Mabel and risks for her of HOTH would be different now, and how? Is there still learning from Mabel's experiences that could inform further practice development in this area.
  - Throughout the discussions consideration of professional challenge and information sharing will take place.

### 3. The methodology and process of the review

#### 3.1 The reviewer, expertise and independence

This review was undertaken by Kelly Dudding, Named Nurse for Children in Care and Lucy Cook, Head of Service for Safeguarding and Care Planning, Children with Disabilities and HOTH.

#### 3.2 The methodology and structure of the report

- 3.2.1 The purpose of this review is to identify strengths in practice and any improvement that could be made to our practice across the system to safeguard and promote the welfare of children. Reviews are not to be conducted to hold individuals, organisations or agencies to account, there are other processes for that purpose. Reviews should seek to prevent or reduce the risk of a recurrence of similar incidents by understanding what happened and why, this review has used the Social Care Institute for Excellence (SCIE)<sup>1</sup> Learning Together systems model. The Learning Together approach is designed to go beyond identifying root causes of particular events and to use a single incident to open the window on the system. The analysis aims to understand the social and organisational factors that influence operational actions and decisions that still sustain influence today.
- 3.2.2 The systems focus analysis requires engagement with professionals working at both operational and strategic levels within and across agencies and professionals as well as family members.

#### 3.4 The review process

The main elements of the process were:

- a) Reviewers considered the merged chronology and agreed key practice episodes in line with the Terms of Reference (ToR) and areas for further exploration and consideration relating to them.
- b) Reviewers considered the key lines of enquiry (KLOE) proposed in the ToR and discussed adaptations.
- c) Facilitation of a Workshop bringing strategic leads of agencies who were directly involved in the case (or working in the relevant services at the time) to draw out an understanding of what happened and why professionals responded as they did and what was influencing their practice and decisions.
- d) Completion of the analysis of professional practice in this case and the systems findings.
- e) Consultation with the Reference Group and practitioners.
- f) Development of the questions and recommendations for the board.
- g) Submission to partnership for the usual quality assurance process.

#### 3.5 The structure of the report

The main body of the report is divided into three main parts:

- **The analysis of professional practice in the case**, which provides a summary of how the case unfolded and judgements on the practice
- **The Review findings, which provides systemic learning** and
- **The Review recommendations**

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<sup>1</sup> Social Care Institute for Excellence (SCIE) Learning Together Methodology [Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE](#)

### **3.6 Methodological comment and limitations**

3.6.1 The LCSPR has been undertaken in three phases, firstly a deep dive of full multi-agency chronologies and relevant documentation, the initial findings were presented to the Executive Group and key lines of enquiry agreed.

#### **3.6.2 Phase 1**

Initially, services submitted their individual chronology's that considered intervention across a two-year period, however given that we were aware that concerns emerged for Mabel at a very young age, a longer-term chronology was requested that considered information held by services that began in 2016. The reviewer analysed the Combined Chronology and Rapid Review Report, plus any additional relevant documentation identified, to consider the above identified themes and produce KLOE for further exploration.

#### **3.6.3 Phase 2**

The second phase involved engaging with Mabel and her family, with a meeting taking place with Mabel, her mother and stepfather.

#### **3.6.4 Phase 3**

A focus groups was convened to explore the themes identified as part of the Rapid Review and any KLOE identified from the longer-term chronology. Managers and strategic leads from the involved agencies were invited to attend.

These included:

- Hartlepool Borough Council Early Help
- Hartlepool Borough Council 0-19 Service
- Hartlepool Borough Council HOTH & Edge of Care
- Hartlepool Borough Council Childrens Social Care
- Hartlepool Borough Council IRO Service
- ICB
- Primary Care
- NTHFT
- TEWV
- Education Provision
- Alliance Psychology

In addition, Stockton Borough Council and Harrogate District NHS Foundation Trust were invited to provide representation equivalent to the above to ensure wider partnership learning.

3.6.5 The review considered the systems and practice across the partnership in relation to child sexual abuse and exploitation and identified learning from both practice and partnership working across the system. This relates in particular to how early life experiences were understood and triangulated to understand Mabel's vulnerabilities and the risks arising from this, by Mabel, her parents and the professionals around them as a collective. They relate in particular to how vulnerability and harm were understood and when risks of exploitation outside of the family home were recognised as a risk factor, were they linked to earlier inter familial harm and emerging concerns about mental health/emotional well-being.

- 3.6.6 The review considered how risks were identified and responded to, the impact and effect of any professional challenge and a consideration of progress made since 2022 when the risks around child sexual exploitation and extra-familial harm were understood. Consideration was also given to the level of critical reflection and professional challenge within and between agencies and a whole system response to extra familial harm and exploitation across safeguarding, enforcement and criminal and welfare systems.
- 3.6.7 The review also focussed on key areas of intervention and support offered to Mabel, and how services ensured support could be identified by Mabel and her parents when ending involvement, and whether this strengthened or impacted on family resilience.
- 3.6.8 The themes identified as key lines of enquiry were the focus of discussion in respect of Mabel and her story, but also in the wider context by a group of strategic leaders. Partner agencies were able to reflect on strengths and key learning from this process to inform practice moving forward within today context.
- 3.6.9 Despite Mabel being an adolescent and having been in secondary school for a number of years, it became apparent at the focus group workshop that it may have been useful and provided additional insight into Mabel's early years had primary school been in attendance. However, it is recognised and acknowledged that due to the number of years that had passed since Mabel had been attending primary school, the learning from primary school may have been hindered by staffing changes and the time lapse since Mabel was in attendance.

## 4. The Review Systems Findings

### 4.1 **Key Lines of Enquiry 1 - How does the system support shared understanding of early childhood trauma when considering presenting risks later in a child's life around their mental health, emotional wellbeing and emerging risks of sexual exploitation and grooming? How do we support parents and children to understand the impact of trauma on future risk and vulnerability?**

- 4.1.1 A question for the review was the consideration of the issue of Mabel's apparent struggles with her emotional well-being and mental health from an early age and whether there was a shared understanding of the underlying potential causes in order to ensure effective information sharing and intervention. The review considered the multi-agency chronology from first referral when Mabel was nine years old.
- 4.1.2 Concerns regarding Mabel's emotional wellbeing/mental health were initially raised in October 2019 by school after Mabel had spoken to her peers about wanting to die and making plans to run away with friends. As a result, school referred Mabel to the Child and Adolescent Mental Health Services (CAMHS). CAMHS completed an initial assessment with Mum and Mabel, and she was placed on a waiting list, which was estimated to be approximately a year long.

A referral to Early help was also made and the family sign were signposted for parental support and Café 177<sup>2</sup>, for direct support for Mabel's emotional health.

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<sup>2</sup> One77 is a social enterprise that provides opportunities that engage and inspire young people. They offer a range of social, practical teaching and learning activities for young people.

- 4.1.3 In April 2020, a contact phone call was made by CAMHS to check in on Mabel's wellbeing. Mum stated that there did not seem to have been any further thoughts or actions from Mabel since October which would indicate thoughts of running away or wanting to die. Mum stated that Mabel seemed to have some curiosity around death and CAMHS felt this was developmentally appropriate and Mum was not concerned there was any risk to Mabel's safety at that time. Assistance to the family through the Mental Health Support Team (MHST) was discussed with Mum and she stated that it may be helpful to Mabel as she could seem down or upset at times.
- 4.1.4 In May 2020, Alliance Psychological Service<sup>3</sup> (MHST) completed an assessment of Mabel. During this her Mum cited several issues of concern including:
- *Mabel had periods where she was pre-occupied with death, though not since Jan 2020, she was isolating herself and had not formed peer friendships, Mabel told her mother she felt depressed.*
  - *Mabel had sporadic contact with her father who had alcohol issues, Mabel was sensitive around alcohol use as a result. Whilst Mabel has siblings, there were big age gaps and so they were not close.*

During the same assessment Mabel was spoken to and reported:

- *She was aware she isolates herself at times.*
- *Also described worries about her father and alcohol use and advises that she struggles to sleep there as a result*
- *She could describe feeling low and anxious but could not say why. She could not articulate what led to her running away from school or thoughts of self-harm.*

The assessment concluded that Mabel had mild/low anxiety and she was offered LICTB (Low Intensity Cognitive Behavioural Therapy). Mabel appears to have engaged well with this with Alliance reporting she attended all sessions, and that Mum was also spoken to regularly.

- 4.1.5 Mabel was supported with LICTB. And whilst Mabel did have a period of decline during LICTB involvement and reported feelings of wanting to self-harm, suicidal ideation and harming those that she believed were not nice to her, she engaged to learn techniques to manage these emotions and reported them to be effective.

By November 2020, both she and Mum described a more positive situation and felt involvement with Alliance could end with all parties in agreement. Whilst Mabel was closed from direct contact, Alliance and school agreed to termly consultations between them to identify any relapse or increasing concerns.

- 4.1.6 In January 2021, the multi-agency chronology makes reference to a strategy discussion that was held in respect of Mabel, however, the context regarding the strategy is not documented and nor is the outcome. This event is significant as it refers to the fact that Mabel potentially had experience of unresolved sexual trauma; again, there is no context or further detail relating to Mabel trauma at that time. It becomes apparent later on in Mabel's life that she had experienced intrafamilial sexual harm by a family member at the age of between 6 / 7 years of age.
- 4.1.7 Following the strategy that was held in January 2021, there is a break in the multi-agency chronology, suggestive of there being nothing of significance to note, until a further referral was made in July 2021. Children's Social Care (CSC) received a referral from primary school after Mabel reported that a peer had tried to have sex with her.

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<sup>3</sup> [Alliance Psychology Service](#)

A strategy meeting was held and a joint Section 47 investigation commenced. During the Police and Social Work interview, Mabel reported historic sexual abuse by a family member, it seemed for a period of a year between the ages of 6 and 7 years. When this was discussed with the family it transpired that they had been aware of the sexual abuse and while there had been no reports to any agency at the time, the family felt they had dealt with the situation themselves.

- 4.1.8 Mabel's Mum did not wish to pursue a Police investigation into Mabel's report of sexual assault by her peer as she felt this was experimentation and as a result, Police closed the inquiry. Social Care continued with a Children and Families Assessment under Section 17 regulations and felt that whilst concerns of sexual harm were substantiated and there were also concerns around Mabel's emotional wellbeing, it did not meet threshold for ongoing involvement, and the family were acting appropriately to protect. Social Care subsequently ended this period of involvement in September 2021.
- 4.1.9 It is important to note that it was also around this time that Mabel began to experience struggles with her identity and began identifying as male. Throughout the preceding years Mabel fluctuated between identifying as female and male and made many changes to the name she wanted to be referred to as. Mabel describes that she did not receive any support about understanding her identity and that she was able to work out herself who she is and what gender she would like to be. Research demonstrates that there are links between gender dysmorphia and neuro development<sup>4</sup> but there are also links between gender dysmorphia and abuse<sup>5</sup>. We know that it is common for children explore and develop their identities and that a young person's gender may change over time<sup>6</sup> but it was reported by Mum that Mabel had wanted to identify as male because she believed boys weren't at as much risk of abuse as females.
- 4.1.10 In January 2022, further concerns emerged when Mum discovered Mabel had bypassed parental internet controls to upload explicit videos of herself and send them to unknown people. The Police investigation could not identify who received the images and videos and therefore no further action was taken.

Alliance made contact with Mum following this incident and a further referral from school (now secondary) was made after they had noted self-harm marks to Mabel's arms and legs. Mum advised that Mabel had also taken overdoses that she had not sought medical attention for and she had also found a knife under Mabel's bed. Mum shared that she had also found handwritten notes by Mabel which appeared to be a plot of how she would go on to kill her Mum.

A decision was made to support Mabel as a Child in Need following these concerns, and a referral was made to Barnardos<sup>7</sup> for Mabel to be supported regarding what a healthy relationship looked like and Hart Gables<sup>8</sup> for work around gender identity. In addition, a Harm Outside the Home (HOTH) meeting was held in February 2022 and Mabel was deemed to be at medium risk of exploitation.

- 4.1.11 During the spring of 2022, there were ongoing concerns regarding Mabel intentionally overdosing on medication, Mum finding she had another phone (after her previous device

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<sup>4</sup> [National Autistic Society](#)

<sup>5</sup> [Office for National Statistics](#)

<sup>6</sup> [NSPCC](#)

<sup>7</sup> [Barnardos](#)

<sup>8</sup> [Hart Gables](#)

was confiscated), further explicit images on the phone and Mabel expressing feelings of feeling unloved. A referral to CAMHS, Getting More Help Team was made.

- 4.1.12 In May 2022, concerns continued to escalate around exploitation, Mabel going missing from home and overdosing. A multi-agency strategy meeting was held and whilst it seemed parents were proactive in intervening to protect; there were risks outside of the home that they could not manage. An Initial Child Protection Conference was held, and the outcome was for Mabel to remain subject to a Child in Need Plan.

There was some disagreement from the School Nurse who felt a Child Protection Plan was needed but there was no rationale in the multi-agency chronology as to why a Child Protection Plan was felt to be warranted by that agency. The decision was made with the majority to continue to manage the risk under Child in Need with the rationale being that whilst the concerns around Mabel's emotional wellbeing/mental health and impact this had on her, her vulnerability in particular her sense of identity and risk of ongoing online exploitation were significant, parents were working with services to reduce risks as far as possible and should not be "penalised".

- 4.1.13 Over the summer of 2022, CAMHS was supporting Mabel and this included a family approach involving both parents and stepparents as well as direct support for Mabel. Parents did withdraw from support, feeling things were improved at home.

At the end of September Mabel took a significant intentional overdose of paracetamol and a further strategy meeting was held. It was reported that this overdose was a surprise to professionals as Mabel had appeared to be feeling quite positive, parents were managing risk well and responding appropriately to her emotional wellbeing in addition to managing and monitoring her internet and phone use. It was agreed a further period of support through Child in Need was proportionate.

Mabel was prescribed medication for feelings of low mood, low self-worth and emotions around adverse childhood experiences. Mabel was attending "the Bridge"<sup>9</sup> at school rather than mainstream lessons and was anxious about going back to a full timetable.

On 3<sup>rd</sup> November 2022, a Child and Family Assessment recommended closure to children's social care, acknowledging the concerns but outlining appropriate support in place from CAMHS, Barnardo's, school and parents managing exploitation risks. This was agreed by all agencies.

- 4.1.14 In December 2022, Mabel's emotional wellbeing continued to cause concern and there were regular appointments and contact with CAMHS. On 21<sup>st</sup> December, Mum contacted Police after Mabel advised she had had sexual intercourse with her 14-year-old boyfriend on two separate occasions. Despite Mabel only being 12 years old at the time of the sexual activity and therefore unable to provide informed consent, there was no further action taken by Police as Mabel shared that the sexual intercourse was consensual. Mabel described wanting a father figure and to be held and told she was loved. Mabel went to stay with her father at this time, and she continued to be supported and engaged with Eye Movement Desensitisation and Reprocessing (EDMR) at CAMHS.

During the Spring of 2023, Mabel continued with support and intervention from CAMHS, she was living between her parents addresses. In April 2023, Mabel changed her name once again and was identifying as a boy. School also referred Mabel for Autism

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<sup>9</sup> Nurturing environment for children, a small number of children are allowed in the Bridge with a limited number of passes. Children can work in the bridge supervised, with relaxing, calming, and regulated environment.

assessments. Mabel reported low mood, thoughts of hurting others and thoughts regarding historic sexual abuse.

4.1.15 Over the summer of 2023, Mabel engaged with CAMHS and was referred to a Sexually Harmful Behaviour Worker who collaborated a plan of systemic and psychoeducation intervention with CAMHS. Parents were also offered sessions as Mabel continued to live between their addresses. Mabel discussed the historic sexual abuse by the family member and made reference to other online relationships with adult males during some of these appointments.

EDMR continued for Mabel and parents received systemic sessions, which continued until February 2024, with family all reporting they felt they had had a positive impact.

Mabel reported that she was feeling anxious about EDMR coming to an end and therefore, a therapeutic ending was discussed and planned. Therapeutic intervention ended in November 2023, and Mabel remained open to CAHMS for medication reviews. There had been a period of stability for Mabel over that summer, and she appeared comfortable with progress and future management of her emotional health.

4.1.16 In February 2025, concerns were raised that Mabel was once again self-harming and Mum was seeking support. In the summer of 2025, Police received intelligence that Mabel had been exploited online and had shared explicit images of herself. During Mabel police interview Mabel reported she was in a 'relationship' with a male she had met via an online forum and who she later discovered was a person working in a position of trust. There has been a parallel misconduct and criminal investigation in relation to the perpetrator of Mabel's abuse. This person was employed in a position of trust and was dismissed within three weeks of the report being made by Mabel and before his conviction. He was found guilty of 21 offences; including 9 counts relating to indecent images of children, 11 counts of sexual activity with a child and 1 count of perverting the course of justice. He was sentenced to 14 years in prison.

#### 4.1.17 Analysis/Findings

It is clear that Mabel was subject to sexual harm from a young age, and research acknowledges that this raises the risk of further vulnerability to sexual harm and exploitation in the future.<sup>10</sup> This alongside her well documented self-image issues, low self-esteem and poor emotional well-being and mental health all raise risk factors to Mabel being exposed to future harm. While research suggests that sexual harm at a young age raises vulnerability to exploitation, it should also be acknowledged that Mabel received a neurodiversity diagnosis in the latter part of 2025 which also increased her vulnerability to exploitation<sup>11</sup>

What is notable from the multi-agency chronology is that this was not triangulated in a timely way. When professionals first became aware of the sexual harm perpetrated by the family member, it was deemed to be a historical event and focus was on whether she was safe at that point. This is of course a reasonable and necessary response when considering present and future risk; however, it does not seem that this information was considered as an underlying factor in Mabel's clear struggles with her mental health. There was no consideration given to link the historical sexual trauma and Mabel's emotional well-being. It was much later when significant concerns were raised in respect of Mabel's overtly sexualised behaviour at such a young age, did the extent of the intrafamilial sexual abuse become clear to professionals.

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<sup>10</sup> Centre of Expertise on Child Sexual Abuse (2023).

<sup>11</sup> [Preventing Exploitation Toolkit](#)

- 4.1.18 The response of Mabel parents at the time of the intra-familial sexual abuse was to ensure there was no opportunity for further harm by limiting the contact between Mabel and the family member. However, it would appear that parents did not understand the links between her emotional needs and experience of trauma and how Mabel would manage having any contact with the family member that had assaulted her. There is no indication that this was discussed at length with parents or Mabel to ensure emotionally, she was supported and parents understood the trauma and impact on her future. The absence of emotional well-being consideration continues as a theme throughout the multi-agency chronology and narrative from services. The information from TEWV and Alliance outlines targeted and consistent support offering a variety of interventions and later medication to support Mabel. There is evidence of agency collaboration across child in need planning and education to provide further support, however this all appears reactive and in response to concerns raised by Mum, who was and remains of the position that Mabel required a mental health diagnosis from an early age.
- 4.1.19 Throughout this review, it indicates that while information was known to professionals about Mabel's early experience of being a victim of intrafamilial sexual abuse, this was not responded to in an appropriate way that considered both children's (Mabel and the family member) young age and vulnerability and their emotional well-being. It appears that professionals were working with "the here and now" in response to Mabel and safeguarding.

**Finding 1**

There has been extensive work undertaken with Mabel and she has been supported at length by specialist services in respect of both her safety and emotional well-being. However, the review has found that safeguarding was not considered adequately for both children as victims in their own right in July 2021, when historical abuse was reported, including recognising the emotional needs, sexual abuse and trauma they experienced.

**Recommendation 1**

HSSCP need to be assured that all children are being assessed and safeguarded when safeguarding concerns are reported. HSSCP Independent Scrutineer completed a deep dive into Child Sexual Abuse (CSA) and as a result the CSA Steering Group are reviewing pathways and amending procedures to reflect current practice.

Once the CSA Steering Group have completed this work, the LSCP will confirm procedures and consider compliance after a period of embedding changes; there will be a further deep dive audit undertaken to provide assurance that all children in the family where there are safeguarding concerns are considered in assessments.

**Finding 2**

It is apparent that in this case that professionals did not consistently recognise the cumulative effect of harm and therefore did not always respond accordingly. Professionals need to be able to demonstrate professional confidence and consider families with an open mindset to enable us to support families in understanding harm and vulnerability to safeguard children and young people.

**Recommendation 2**

The LSCP will review multi-agency training that is offered to professionals in understanding cumulative risk, harm and vulnerability and we will also ensure that multi-agency partners have identified single agency action planning in response to addressing this finding.

As a partnership we will review recommendations from findings and explore developing tools or guidance to help professionals in consistently considering cumulative harm.

#### **4.2 Key Line of Enquiry Two - What does effective intervention look like? More specifically how do we ensure families understand who is supporting and why, and what support looks like moving forward when services retract support or are unable to support.**

- 4.2.1 We know that Mabel received extensive involvement from various services from the age of nine years, in particular from mental health and therapeutic services through TEWV, Alliance, and Barnardos. In addition, Mabel also received brief intervention through an Early Help Assessment, which progressed to a further referral to CAMHS and later support under Section 17 of the Children Act from Children's Social Care.
- 4.2.2 When speaking to Mabel and her family they were clear that they had felt the intervention was most effective and supportive regarding Mabel's mental health during the times when both Mabel and parents had their own sessions and point of contact within Alliance. It is evident from the multi-agency chronology that when the decision was made that work had come to a natural end and Mabel had made progress, the decision was made in collaboration with professionals and the family and extraction was managed carefully. This included Mabel receiving specific sessions to manage the end of the support and discussions around how to contain and manage in future if or when there were challenges. Follow up reviews were proposed with school, so whilst Mabel may not have had direct contact with a professional from Alliance, her situation and presentation were to be reviewed regularly to anticipate any changes and deterioration. What is less clear is if this took place, as clearly Mabel did experience some lapses, and it may have been beneficial to have a quick response from Alliance staff who knew her well.
- 4.2.3 The involvement with Alliance at this time can be seen as positive. Mabel felt it was beneficial and her parents also advised they felt supported, listened to and less anxious when the involvement ended than they had in other situations when support had reached its conclusion. However, Mabel, Mum and stepfather shared that throughout the many years of intervention, they were often left feeling that professionals believed Mabel to be too complex and that as a result services were unable to work with or support Mabel and the family. Mum and stepfather went onto verbalise that when referrals were made but intervention unable to progressed, Mabel was not supported to find the correct service able to support. For example, in December 2022, a referral was made to the Early Intervention in Psychosis team for visual and auditory hallucination, but a referral was unable to be progressed due to Mabel not being of an age whereby a referral could be progressed. Mum shared that quite often professionals made her feel that she was the parent, and it was up to her to 'sort the problems'.
- 4.2.4 From the multi-agency chronology it is clear that there is a wealth of support and interventions from various agencies across the partnership, and generally information sharing and co-ordination of planning appears well communicated. The multi-agency chronology demonstrates that largely key agencies within the partnership had shared knowledge of specific events, such as when concerns of exploitation emerged. What is perhaps less clear is how this was triangulated and how it was identified which agency would focus on what element of need. There is a suggestion that there was an over reliance on prioritising Mabel's emotional well-being rather than addressing directly the

risk factors, such as challenge with the Police about their response to the sharing of videos and any investigation into perpetrators.

- 4.2.5 Key transition points, such as from Primary to Secondary School, were considered within the focus group in relation to services supporting Mabel's emotional well-being and addressing safeguarding concerns. The focus point of the plans within these episodes of intervention considered Mabel perception of herself, the relationship with her parents and parents' responses to risks and vulnerabilities. Mabel and her family mostly presented as a family who recognised they needed support, and could also voice that they felt things had improved. However, it appears that services withdrew support or handed over to other interventions without any consideration of why things appeared more settled and stable, and what the response would be if there was deterioration.

As professionals we need to understand what and how intervention has appeared to work when exiting from families, this understanding would help us to help families to sustain positive change, minimise risk of lapse and continue to build families resilience moving forward. However, what we also know is that when children are being exploited, they often experience positive feelings and attention which contributes to an outward presentation of feeling happier and settled, and therefore less likely to exhibit some of the behaviours Mabel had been<sup>12</sup>. Therefore, it is important when services are ending and withdrawing, we are clear about impact and plans moving forward and build a forward plan with families/children.

#### 4.2.6 Analysis/Findings

From considering the multi-agency chronology as a whole there are clear patterns around positive and proactive parental response. On many occasions Mabel appeared to speak with professionals and be open to support. As Mabel ages and transitions to secondary school it is clear that therapeutic intervention and support had some positive impact, and that family and school were provided with clear strategies to support Mabel in the future and parents reported that they felt assured with this course of action. However, as Mabel reaches puberty and adolescence it becomes apparent through her own narrative, she remained impacted by the sexual abuse and a fractured relationship with her father. Mabel behaviours escalate in terms of self-harm, suicidal ideation and overdose, before concerns around her sharing explicit images of herself and becoming sexually active by the age of 12 years manifest. Services appear to be reactive, and process driven in terms of pathways for intervention out of Alliance and into CAMHS, consideration of social care threshold, HOTH intervention and timetable changes from education. Whilst none of this was to Mabel's detriment, individual services appeared to be addressing Mabel's needs from their own service delivery perspective, and there did not appear to be a shared understanding of the impact of the underlying issues and how this could be addressed by drawing together multi agency skills and knowledge, despite Mabel raising them and making further reports of relationships online with adults and craving a father figure. Had the cumulative harm to Mabel been considered by each agency, alongside a clear understanding of what Mabel needed to ensure her safety and well-being was maintained, this may have increased concern and vigilance around both online inappropriate relationships and exploitation and therefore Mabel's increased risk offline.

- 4.2.7 When Mabel turns 11 years, concerns begin to return and escalate in respect of online exploitation and Mabel presentation and perception of herself and her worth, both in her identity and also in her relationships. This episode of support with social care involvement,

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<sup>12</sup> Hartlepool & Stockton-on-Tees Safeguarding Children Partnership. Local Child Safeguarding Practice Review "Child Joe" (2023)

secondary school and CAMHS is again co-ordinated, however there is little indication of meaningful information sharing regarding the history, relationships around Mabel and the impact this may have been having on her emotional well-being.

Whist intervention and therapy is well documented and parents and Mabel report this being successful in the main, there is no evidence it changed parents' approach and understanding of Mabel risk and vulnerability.

Parents continued to be responsive when concerns emerge by confiscating Mabel's phone and contacting professionals for help, parents did not appear able to show any insight into trauma Mabel had and was experiencing, instead appear to feel that Mabel had underlying and diagnosable mental health problems that required medication.

There is little evidence of any direct professional challenge to parents regarding their thinking and how Mabel then perceives herself. In her own words Mabel "wants to know what is wrong with her head", indicating that Mabel has always felt that the issue about her feelings to be mental illness and not trauma and that these two things, whilst interlinked, are very different in how they should be approached and supported.

- 4.2.8 From the multi-agency chronology and considering responses to Mabel emotional wellbeing and associated behaviours it is clear that when the right services became involved and were consistent to Mabel, this allowed her to form meaningful professional relationships and make progress. However, this progress was not sustained and things manifested over time to further events and subsequent significant harm.

This suggests that despite the significant involvement from services, understanding the underlying causes for Mabel's behaviour did not appear to be wholly understood by professionals and therefore Mabel and her family were never appropriately challenged in respect of their belief Mabel had a mental health diagnosis. Perhaps if parents had been supported to understand Mabel's trauma and its impacts, this may have supported all to understand the vulnerability and future harm within Mabel relationships and the susceptibility to sexual abuse and exploitation, which occurred on several occasions online and in "real life".

- 4.2.9 In conclusion, whilst there were many strengths in professional activity, there were also opportunities to be more curious and communicate more openly about trauma and the future risks associated with this. When considering the barriers to the system can we be assured that when intervention ends but then is required to begin again, services and professionals offer their support where it had ended and that 'start again' syndrome is not imparted to children and families.

### **Finding 3**

Information was shared through the child protection conference process and Mabel accessed services where information was also shared with partner agencies. Despite the severity of what had happened to Mabel, this was considered in a multi-agency forum, and a decision was made that there would be no further action to be taken.

### **Recommendation 3**

Lengthy discussion has taken place with all partner agencies who were heavily involved in supporting Mabel with reflective challenge being made with all professionals in agreement that even with hindsight bias, there is not anything that could have been undertaken differently that would have protected Mabel from experiencing further significant harm.

It is also felt that with the other recommendations within this report, information sharing and triangulation of information will continue to be considered by all professionals, therefore there is no recommendation to implement in respect of finding 3.

**4.3. Key Line of Enquiry 3 - It is recognised that the approach to Harm Outside the Home (HOTH) within Tees has progressed significantly in recent years. How can we reflect on this progress, and do we consider the response to Mabel and risks for her of HOTH would be different now, and how? Is there still learning from Mabel's experiences that could inform further practice development in this area.**

4.3.1 An Initial Child Protection Conference (ICPC) took place in June 2022 due to concerns in respect of Mabel's mental wellbeing after taking a significant overdose in May and Mum finding another mobile phone containing further explicit images. The outcome of ICPC was for Mabel to continue to be supported via a Child in Need plan, despite it being noted that two separate agencies dissented to this decision (School Nursing and CAMHS). Despite some dissent, the outcome of the ICPC was to proceed with the majority decision and the child in need plan to remain and it wasn't clear from the dissenting agencies' records any rationale for why they had chosen not to escalate this further. The Rapid Review panel noted that the Tees 'Professional Challenge, Escalation and Resolution of Disagreement' has recently been reviewed and strengthened with briefings being shared across multi-agency to reinforce with professionals the expectations around escalation and recording of rationales. In addition, it was noted that a new 'ICPC Dissent' procedure has recently been agreed. Both of these recent changes would support future practice in similar circumstances.

4.3.2 Despite Mabel being open to the Harm Outside the Home (HOTH) agenda between February 2022 and April 2023 as medium risk of Child Sexual Exploitation (CSE), HOTH had not been invited to the strategy or subsequent ICPC. This was a missed opportunity for HOTH to input their information and whilst this may not have altered the outcome in terms of CIN, it would likely have strengthened information sharing and identified actions. HOTH, called MACE (multi-agency child exploitation) at the time, was still fairly new in its development and it is noted that there have been significant changes locally over the past year in respect of Harm Outside of the Home pathways and practice.

On reflection, the HOTH involvement today in similar circumstances would have looked different for Mabel as the timeliness of HOTH reviews being held and any decision to remove children from the HOTH agenda was not robust enough at the time Mabel was initially considered. Learning around this has already been translated into action and changed as part of the recent local HOTH review and development work. HOTH reviews are now more frequent (4 weekly for high risk and 8 weekly for medium risk), collaboration with social care is stronger and the response to missing episodes has been strengthened. It was known that Mabel had missing episodes that were either not reported, recorded or responded to by Children's Social Care, whereas now, missing episodes are coordinated by HOTH with return home Interviews completed and analysed by professionals working within the HOTH arena.

4.3.3 It is noted within HOTH's single agency analysis that there had been a number of incidents where Mabel was exposed to sexual harm/abuse which were not reported to the police, however, the response and action taken by the police to those reports that were made is unclear and not reflected within social care records.

An example given was from May 2022 when Mum discovered 4 phones with graphic images on that had been sent to Mabel by adult males and it wasn't clear from social care records what action was taken by Police. Police advised the Rapid Review panel that several perpetrators' usernames were ascertained, however, none were based in the U.K.

It was noted that there appears to have been a breakdown in communication to 'close the loop' in terms of ensuring involved agencies were made aware of the outcome of any investigation.

This was felt to be a further missed opportunity, particularly given the number of perpetrators discovered most recently on Mabel's ceased phone. Police have considered this to be a single agency learning point and are considering actions.

4.3.4 The Focus group queried what had been achieved in terms of multi-agency intervention and support at point of Mabel's closure to Social Care and HOTH in 2023 and how professionals were assured things had improved for her. Professionals in attendance found this difficult to answer; it was recognised that with the benefit of hindsight, there had been an element of over optimism in Mum's ability to safeguard Mabel. It was noted that Mum and stepfather were reported throughout multi-agency records to be doing all they could to protect Mabel, but the Rapid Review Panel reflected upon and acknowledged how difficult this is to do when harm is outside of the home and beyond parental control.

4.3.5 The Children's Hub (CHUB) single agency analysis noted that, 'given the increase in referrals/concerns about child-on-child sexually harmful behaviour/sexual abuse and online child sexual abuse, and given that the age of children subjected to these types of abuse/harm is becoming increasingly younger, we must consider whether there is a higher level of acceptance/tolerance amongst multi-agency practitioners and whether this is impacting on the threshold being applied and the intervention and support provided to the child.'

#### 4.3.6 **Analysis / Findings**

While it is clear that information sharing is robust during statutory meetings such as strategy discussions and child protection conferences, we do not appear to have the ability to share outcomes in a timely way. When risk is recognised and addressed, all agencies need to continue to work together to support outcomes for children and families and they can only do so when they are kept up to date with the outcomes of assessment / investigation. There appears to be a more co-ordinated approach to HOTH with clear process and responsibility, but we need to ensure that the right services are supporting children and families and that concerns do not 'slip through the net'. We can only become optimistic in respect of safety once we are assured that specialist support and intervention have been actioned.

4.3.7 Professionals need to remain sceptical when feeling assured that parents are able to protect children from risk outside of the home. Professionals need to consider if we are placing too much responsibility on parents to safeguard children and young people when they do not feel or are not equipped to do so. Professionals need to ensure that work is undertaken with parents whose children are at risk of exploitation to understand the 'push and pull' between victim and exploiter and that assumptions are not made in respect of knowledge and ability to protect.

**Finding 4**

While it is recognised that we have made significant progress over recent years regarding our approach to Harm Outside the Home. It is recognised that a large amount of this focus on this has around supporting children, we also need to support wider family, parents' carers and siblings to recognise and respond to risk.

We need to be assured that we are supporting parents to effectively safeguard children when threshold has not been met for statutory service involvement.

**Recommendation 4**

Strategic HOTH is to consider developing advice and support specifically for parents and to contemplate how parents whose children who don't meet the threshold for statutory service intervention are supported to maintain safety. For example, we could consider utilising multi-agency partners / trusted professionals to support families in recognising vulnerability and addressing risk when there is no role for statutory services.