City of York
Safeguarding Children Partnership

7 POINT BRIEFING:
Poppy - Learning from Practice

Poppy Local Safeguarding Child Practice Review (LSCPR)

1. Who was Poppy?

Poppy was a 16-year-old female who contacted the Police to allege she had been raped by multiple males. Poppy had previously been known to Children's Social Care, and both she and her elder sibling had been subject to Child Protection plans on two separate occasions between 2015 and 2017. Historical concerns of potential Child Sexual Exploitation (CSE) focused on the older sibling and support was put in place. No direct work regarding CSE was undertaken with Poppy during either period she was subject to a Child Protection plan.

A Rapid Review concluded that there were many missed opportunities to intervene positively to protect Poppy and a Local Safeguarding Child Practice review was undertaken with a particular focus on changes in practice since 2017, that could have ensured Poppy was safer.

2. What areas of good practice were highlighted?

At the time of the incident the following areas of good practice were identified:

- All agencies worked together effectively to ensure Poppy was safeguarded and receiving appropriate support in response to her rape allegations.
- Agencies worked well together to respond to the needs of Poppy.
- North Yorkshire Police appropriately referred the case to CSC.
- A Strategy Meeting was held appropriately and involved key agencies including Education.
- A referral was appropriately made to the Sexual Health Service to support Poppy following the incident.

3. What were the key learning points?

Learning Point 1:

There were missed opportunities to work with Poppy directly at the time of the Child Protection Plans in 2015 and 2017. Interventions at the time predominantly focused on concerns for the older sibling. The impact of her sister's behaviour on Poppy should have been considered, including the potential for the elder sibling to influence Poppy's behaviour. Poppy disclosed in 2017 sexual touching of a male, reporting to school that she had met a male who had asked her to touch him. Poppy was 12 years old at the time of the incident and the perpetrator was 19. Given the significance of this incident, Poppy should have been supported in her own right to address her vulnerability to exploitation.

Learning Point 2:

The length of time both siblings were on a Child Protection Plan in 2017 was short given the significance of the incident and vulnerabilities in the family. The family were reluctant to work with CSC and it was assumed the risk had been reduced. At the time it was noted that the Hand in Hand Service (commissioned third sector service supporting victims of exploitation) and School did direct work with Poppy regarding healthy relationships.

Additionally, both siblings had been on a CP plan for emotional, not sexual abuse in 2017. However, it is recognised that practice in York has changed and the partnership has undertaken a number of actions to ensure CP plans do not lose sight of the impact of sexual abuse for child/ren and their carers. These have included: a dual CP category pilot in cases of sexual abuse where CSA or HSB would be maintained alongside a category of neglect or emotional abuse, introduction of the Exploitation Team within CSC, the development of the Adolescent strategy, a new partnership Child Exploitation Subgroup and the introduction of the new HSB procedure, OMG and multi-agency training. All of these outcomes should lead to better outcomes for sexually abused children.

CYSCP now has monthly Multi-Agency Child Exploitation and Missing meetings (MACEM) where partners share information where there are concerns that a child or young person is at risk of or is being exploited, or is frequently missing from home or care.

Learning Point 3:

Between 2018 and 2020 Poppy attended the Sexual Health service on 10 occasions: on 6 of those occasions for emergency contraception. Within the same period, Poppy also attended the GP practice on 5 separate occasions with non-specific abdominal pain. This information was not triangulated. Poppy self-referred to the Sexual Health Services and reported a regular sexual partner, the same age as her, and having consensual sex. Sexual Health completed the Brook screening tool at each attendance. The answers Poppy provided did not give cause for concern, therefore a record of attendance was not shared with the GP. The GP did not refer Poppy to Sexual Health Services as she denied she was sexually active. Poppy gave different accounts to the Sexual Health Service and the GP so there was no consideration given by Health Colleagues as to whether Poppy was accessing services elsewhere and her non-specific abdominal pain was not considered in the context of frequent attendance at the Sexual Health Clinic. Additionally, there was no direct contact from CSC to the GP whilst the siblings were subject to CP Plans to alert them of concerns re CSE.

Learning Point 4:

Poppy's sexual health history was not considered by staff managing presentations with abdominal pain. Assessments at each presentation through the Emergency Department and services across the Hospital did not give rise to concerns about safeguarding. Consideration should have been given as to whether Poppy may have had PID (Pelvic Inflammatory Disease) which can be, but is not exclusively a sexually transmitted infection or a result of other bacteria.

Learning Point 5:

Poppy was a frequent attender at the Sexual Health Clinic, and this should have triggered further conversations with the York Teaching Hospital NHS Foundation Trust Safeguarding Children team with consideration of a referral to Children's Social Care. The Sexual Health Service was not aware of Poppy's history or that she had been subject to a CPP as she did not disclose a history of involvement for her family with CSC despite being asked.

Learning Point 6:

The Sexual Health Service ICT system and the York Teaching Hospital NHS Foundation Trust ICT system are different and neither communicates with the other. This had previously been raised as a concern by the Sexual Health Service prior to this incident. Sexual Health Staff therefore had no ability to check information held on the YTHFT ICT system, so those checks did not happen for Poppy, also partly because assessments completed by sexual health staff did not give cause for concern.

Learning Point 7:

The Sexual Health Service should more closely and holistically consider all children and young people who are frequent attenders.

The lead for Sexual Health Services, in partnership with the Safeguarding Children Team at YTHFT will consider developing frequent attender guidance specifically around children attending to access emergency contraception.

4. Key Recommendations:

- A masterclass briefing of the learning from the case to be delivered and added to CYSCP website.
- Development of a process of communication between YTHFT Sexual Health services and Primary Care.
- YTHFT to review processes for consideration of safeguarding when a young person is a frequent attender.
- Training to be undertaken with the Emergency Department and Paediatric staff for consideration of sexual activity when a young person attends with abdominal pain.
- Process for flagging of children and young people at risk of CSE on health systems to be developed.
- Process to be developed for Sexual health staff to check wider IT systems within YTHFT for relevant attendances where there are concerns relating to multiple attendances.

5. Covid Specific Learning:

- Agencies such as the ISVA have not been able offer face to face appointments to Poppy and this has left her feeling unable to access much support. A conversation has taken place with the ISVA and following it has been confirmed that face to face appointments with Poppy are now taking place.
- Had Poppy been at school her reduction in attendance, as a result of her attendance at the GP/Hospital would have been noted. Poppy was not in school at the time of the alleged rapes, as she was not open to CSC and would not have had a "vulnerable child" place at school.
- Poppy was waiting for an appointment with gastro-enterology at York Hospital which may have been delayed due to the pandemic.
- No obvious negative impact on the Police response or Investigation.

6. The Voice of the Child

Poppy was not spoken to as part of this review due to an ongoing police investigation but the review considered her lived experience as does the subsequent action plan. There are plans to meet with the family and Poppy to discuss this review when it is appropriate to do so.

7. Next steps for City of York Safeguarding Children Partnership:

The specific actions arising from this LSCPR will be taken forward by the CYSCP.

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