Wandsworth Safeguarding Children Partnership

Local Child Safeguarding Practice Review ALSAMI

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1. Introduction

The passing of a young life by suicide is a moment for agencies to pause and to consider their work with the family and what lessons can be learnt to improve practice. The pause provides an opportunity for the partnership to reflect on the learning from this review to inform its practice.

Alsami was described by his primary school as "*a quiet student"*. He had many friends and was popular. He enjoyed school plays and he played the lead role in Aladdin at very short notice. Alsami took pride in his appearance and always "*looked smart with shiny shoes, ironed shirt"*. In senior school he had many friends and enjoyed his time in the school. Alsami was described as *"a lovely pleasant young person"* by Secondary School professionals. Alsami's mother has told the chair of the review panel and the reviewer that "*he was a joker, made everyone laugh"* and he told his mother to *"be happy".* At the time of his sad passing, Alsami was in good physical health and he was not attending school. The reason Alsami was not attending school was that his mother had requested a transfer to another school.

The review author of this report is very thankful to Alsami's mother and his primary school for supporting her engagement in this review. The chair of the review and the review author are grateful for her time and her honest perspective which was understandably very difficult for her.

The author is also very grateful to all professionals who have contributed openly to this important process. Professionals have provided rigour and challenge to their own work and supported colleagues through some very difficult and challenging discussions.

Further thanks to Alsami's senior school and his peers for their engagement in supporting the chair of the review and the review author to understand what life is like for adolescents of Alsami's age (many of whom were his friends) and lived in his area. The session arranged by Alsami's secondary school was a very powerful input and has enriched this report. It has provided the review chair and review author with an enhanced understanding of Alsami's lived experience generally and within the school.

The author is thankful to the Chair of the LCSPR who has provided sensitive and carefully navigated leadership by both supporting and challenging in appropriate measures when required. The WSCP Manager's wisdom on safeguarding and knowledge about the wider partnership has been helpful in progressing this LCSPR.

The themes in this report are drawn from discussions with Alsami's mother, professional input in the form of Independent Agency Reports and Independent Management Reviews provided by individual agencies. The discussions at the panel meetings and the practitioner event were critical in shaping and identifying themes in the review. The practitioner event provided rich and invaluable insight into Alsami's personality, lived experience as well as agency interventions. It was very well supported by all agencies involved.

2. Why this case is being reviewed?

Alsami took his life by suicide in June 2021. A call was received by the London Ambulance Service [LAS] that a 14-year-old boy had taken his life and was sadly believed to have passed. Attendance to the home by professionals confirmed this. A suicide note indicated that Alsami felt that his family would be better off without him. The note is significant in its impact and poignancy of a young man in considerable distress. Alsami's voice has been heard in panel discussions and will not be considered in detail in this review to respect confidentiality and out of sensitivity to his family. At the time of his sad death, Alsami and his brothers and sisters were open to Children's Social Care. A Section 47 enquiry was completed, and a Child and Family Assessment was being progressed to inform threshold and response to need . The referral was in respect of Alsami's older brother and sister and concerns that the family home environment was '*unsettling and disruptive'*. Records indicate that there were concerns that the siblings were having fights with each other using knives.

3. Time Frame for the review

The review scope is from **Jan 2020 to June 2021.**

4. Family composition

Subject	**Age**	**Ethnicity**	**Relationship**
[Alsami]	14yrs	Asian: British/ Pakistani	Subject
Sibling 1 – father not the same as Alsami		Asian: British/ Pakistani	Brother
Sibling 2 – father not the same as Alsami		Asian: British/ Pakistani	Sister
Sibling 3 – father not the same as Alsami		Asian: British/ Pakistani	Sister
Sibling 1 – father the same as Alsami		Asian: British/ Pakistani	Sister
Sibling 2 – father the same as Alsami		Asian: British/ Pakistani	Brother
Sibling 2 – father the same as Alsami		Asian: British/ Pakistani	Sister
Mother		Asian: Pakistani	Mother
Alsami's father		Asian: Pakistani	Father of 4 eldest children
Father to youngest three children.		Asian: Pakistani	Father of 3 youngest children

5. Family participation.

Two meetings were held with Alsami's mother to understand her perspective about what happened and her experience of receiving services. The meeting was held in Alsami's primary school with his mother, the review chair, review author and staff from Alsami's primary school. This meeting provided the family perspective on the work of professionals, the relationships within the home and the home environment that Alsami was living in. The meeting provided a powerful insight into Alsami's lived experience within the family home. Very personal and sensitive information was shared with the Chair of the review panel and the review author. This has been respected and shared sensitively where appropriate and relevant in this review. The report was slightly amended after consultation with Alsami's mother. No substantial changes were made on the themes or learning set out in the report.

6. Themes

6.1 Theme: Knowing the child and his lived experience.

Alsami

Alsami's internal life as described in his suicide note is one of trauma, feelings of isolation, concerns about being a '*burden*' at best and at worst a feeling that his removal from the family would improve lives for others. This internal trauma was not known by professionals or those around him. In the meeting with Alsami's mother, she verified that Alsami's internal distress was not known to the family and that he often presented as a joker and was always trying to keep others *'happy*.'

This poses a question about how professionals can be proactive in building relationships with young people to enable them to have the confidence and trust in adults to share their feelings of despair when life becomes unbearable. This is especially important when they cannot see a way to cope with or navigate their feelings about their situation. Alsami would have wanted to live in a home where he felt valued, loved, and cared for. He was clearly loved by his family; however, his internal dialogue as communicated in his suicide note was that his family would be better off without him.

The discussion with Alsami's peers in his school provided a window into the lived experience of young people within the Borough. Their input has been very valuable in understanding areas that young people are concerned about and how their internal world and 'worries' interact with the external world. They shared how they manage their worries and who the trusted adults are in their lives. They explained that when they have moments of emotional difficulties that adolescent life presents them with, they have people to turn to.

One of the key themes of this review is the importance of rigour in listening to young people. That is not only in the language they use to explain their situation, but to go further into the words that they do not speak. In addition, the review highlights the importance of triangulating information from young people's lived experience with what they are saying or not saying, changes in their behaviours and *"really checking in with them*". Professionals must navigate their understanding about the lives of young people where there is a dissonance between seeing the happy child and the reality of someone who is not coping but presents the world

with their happy face. In some situations, young people present a face that does not draw attention to their deep feelings of unhappiness, despair and hurt.

The partnership action plan based on this review will explore how the partnership will work together to identify and work with triggers, or signals from young people. Following the meeting with Alsami's mother and the school, the chair of the review has already begun to implement learning on young people feeling safe in their communities. In addition, the partnership will consider how to support young people so that they have trusted adults to turn to when they are feeling despair that can be so significant that they consider taking their lives.

Young men of Alsami's age and disposition are less likely to '*talk'* to others and therefore some specific and nuanced work may be required to understand their concerns. "*Translated, the word "alexithymia" means "without words for emotions"* [1](Soni et al., 2018). *What this means, essentially, is that the individual with it struggles to understand, process, or describe their emotions* (Panahi et al., 2018)[2]. *Research indicates that alexithymia occurs more frequently in men than women (Leonard, 2019).*[3]

For men, the performative nature of masculinity can be exhausting.[4] Further, research indicates that young men or boys who are brought up in a family with traditional gender roles, there is a tendency to supress emotions. "*Though not rooted in direct relational trauma, male gender role socialization teaches boys to suppress emotions and deny feelings they have of vulnerability, passivity, or tenderness*" [5] (DeAngelis, 2001)

An enhanced understanding of the gap between the world that young people, and especially young men live in and that of professionals is difficult to bridge; but if progress is to be made in reaching out and working with young men who are facing significant unhappiness this needs to be considered. This also highlights the issue of intersectionality in respect of race, gender, sex, religious background and ethnicity.

6.2 Theme: Lack of consideration for cultural & religious nuances and the meanings it had for how Alsami was understood and how he saw himself.

The understanding and engagement with Alsami's faith, heritage, and culture and its impact on Alsami and his family is not as clearly evidenced in the work that has been reviewed. He lived in a South Asian family with his mother, stepfather and his brothers and sisters. Assessments and interventions indicate that there is little exploration or reflection about the significance of Alsami's background in the work carried out with him as it could have been.

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[1] Soni. Soni, P., Bhargava, T., & Rajput, U. (2018). Gender Differences in Alexithymia. The International Journal of Indian Psychology, 6(2). https://doi.org/10.25215/0602.114

[2] Panahi Panahi, M. S., Hoseinzadeh, A., Razaghpour, M., & Hosieni, N. (2018). Formulating a model for the relationship between alexithymia, social support, loneliness, and marital satisfaction: Path analysis model. Journal of Family Medicine and Primary Care, 7(5), 1068–1073. https://doi.org/10.4103/jfmpc.jfmpc_3_18

[3] Leonard, J. (2019, September 25). Alexithymia: Symptoms, diagnosis, and links with mental health. Medical News Today. https://www.medicalnewstoday.com/articles/326451.

[4] Soni, P., Bhargava, T., & Rajput, U. (2018). Gender Differences in Alexithymia. The International Journal of Indian Psychology, 6(2). https://doi.org/10.25215/0602.114

[5] DeAngelis, T. (2001, December). Are men emotional mummies? Monitor on Psychology. https://www.apa.org/monitor/dec01/mummies.

It is important that proactive, knowledgeable, and nuanced understanding of a child's cultural background is included in all aspects of work with him/her. Alsami's suicide note refers to god. It is unfortunate that professionals do not appear to have engaged with him in respect of his religion and background. In one-to-one discussions with Children's Social Care, there is acknowledgement that further work could have been carried out to understand the influence of Alsami's background on his lived experience.
It is not possible to be certain that child focused conversations about Alsami's identity did not take place with Alsami. However, it has not been possible to evidence that they have either. If these discussions had taken place, they would have provided a crucial insight into the impact of his religious and cultural background on him and his views and values. Further, the question is, what work was carried out with him about his experience of racism, discrimination, and Islamophobia?

This has been recognised as an area for further work in the Children's Social Care Independent Management Review and this has begun within Children's Services as part of the implementation of systemic practice. The Wandsworth Safeguarding Children Partnership will want to reflect on how other agencies can address this aspect of their work with Alsami and his family and how this will be addressed in working with families in future.

6.3 Theme: The impact of Adverse Childhood Experiences on children.

Adverse Childhood Experiences (ACE's) can provide a mirror into understanding patterns of behaviour in childhood and later life. Professionals differ about ACEs and trauma informed practice. The longer children live in abusive environments the more likely the impact of Adverse Childhood Experiences. For example, Alsami's older brother and sister were at risk of going missing, afraid of alleged forced marriage and fearful of sexual abuse. Alsami and his mother experienced Adverse Childhood Experiences from an early age. He was known to Children's Social Care since 2010, eleven years prior to his sad death. He and his brothers and sisters were subject to Child in Need and later a Child Protection Plan.

In May 2011, when Alsami was four years old, following injuries to his inner and outer ear, he was placed on a child protection plan. Following these incidents and allegations of sexual abuse of Alsami's sister, the threshold was met for legal proceedings and an interim care order was sought by the Local Authority and granted by the court. During the criminal proceedings against Alsami's father for sexual abuse of his sister, the Interim Care Order was in place. However, this was superseded by a supervision order after Alsami's mother agreed to signing a working agreement. The Working Agreement was made by the Court as part of negotiations in court. Previous reviews have found that working agreements are difficult to progress and not as purposeful in safeguarding children. Children's Services no longer use 'written agreements' as they contradict the model that the service uses. In this instance the 'written agreement' was part of the legal proceedings in respect of Alsami and his siblings.

The long standing and complex safeguarding concerns highlighted the chronology of abuse, emotional neglect, absence of positive parenting and positive male role models. These were multi layered and are difficult to assess as is the long-term impact of them on Alsami and his brothers and sisters. The response with Child in Need plans over time does not appear to have had the impact on outcomes for children in the family. The care proceedings were based primarily on the successful criminal conviction of Alsami's father for sexual abuse against his sister. Whilst the criminal trial against Alsami's father resulted in not guilty, the brothers and

sisters were facing other challenges including the aftermath of sexual abuse allegations because of additional pressure on their mother. This poses the question about what happens to children after they have disclosed sexual abuse and in their eyes the perpetrator has not been convicted of the crime and they feel they are not believed.

How were Alsami's mother's care and support needs assessed following this period in their lives? Her needs as a now lone parent with children who were impacted upon by abuse and domestic abuse do not appear to have been fully considered. She was caring for children who were traumatised by the allegations of the sexual abuse, criminal trial, and she herself had her own needs based on her experience of ACE's.
When consulting Alsami's mother for her views on the report, she told the Chair of the review and the author that: she felt that *"professionals were ticking boxes (in progressing the plans) and did not ask or enquire about her support needs or wellbeing*." She said that when asking for help, parents should be considered and not told *"what can't be done"* or that *"there is only so much we can do."*

6.4 Theme: 'Sensitive and Quiet' children in large complex families.

Alsami was the quiet child in his family. His older brother and sister were the focus of professionals because of their missing episodes and other safeguarding concerns. Allegations were made about alleged forced marriage. Alsami was described as '*getting on well'* with both his older brother and sister. However, on one occasion, his brother physically hit Alsami and made threats to him. The home is reported to be full of tension and conflict.

The information shared indicated that at the time of the incidents or threats, parents were not available in the family home. Alsami's mother told the review chair and the review author she was able to advocate for Alsami. Emotional neglect is a thread that seems to have been prevalent in Alsami's life and potentially in the lives of his brothers and sisters.

Working with large families can provide a challenge for professionals and the focus is often on children who are presenting with the riskiest behaviours. This can sometimes mean that there is little work with the '*quiet children'* or '*sensitive children'* in the family. Therefore, no thorough assessment is made on the impact of their lived experience in a family where abuse, emotional neglect is persistent. Records indicate that Alsami was more sensitive and needed more attention and parental involvement than the other children. In fact, it could be the case that as the middle child of seven children, with older brother and sister subject of Children's Social Care and School concerns, he did not receive the attention he needed.

6.5 Theme: Trauma informed practice – Purposeful engagement with the child to understand his lived experience.

The number of referrals to children's social care and the number of plans progressed suggest that there was underlying trauma in the family. Alsami's father, who is also birth father to his older brother and sister was abusive to their mother and Alsami experienced physical violence. Alsami's stepfather's role is not known in any great detail. There is considerable research and SCR and LCSPR information about the importance of fathers in families and for Alsami the male role modelling from his stepfather could have been explored further.

Alsami's older siblings who had experienced trauma in the household expressed this externally by '*going missing*' (Alsami's sister), his older brother who was at risk of criminal exploitation. Both his brother and sister had mentors at school because of their presenting

needs. This review highlights the importance of understanding and responding to trauma for all children in a household. Children's Social Care are due to implement the think family approach. Within this approach, and other relevant interventions, it is essential that the impact of trauma on all siblings and the presenting needs of carers are considered in work carried out by professionals.

Alsami's suicide note provides an insight into his beliefs about his role in the family, the impact he had on others and his view that if he were no longer in this world, the world would be a better place for his family. This view was an internal dialogue that was not explored with him. It is clearly difficult to do so because as all professionals have reported, he did not present outwardly as a risk to himself or others at any significant level.
The challenge is to explore further, to consider what life was like for him and the impact of trauma had on his view of himself and his world.

Alsami was seen by the Social Worker in Children's Social Care. She was committed to supporting Alsami and his family. The learning here is what discussions take place when children are seen alone? How can social workers, teachers and other professionals who work with children support them with their deeper concerns, worries and the impact of ACEs and childhood trauma? The author understands from the Children's Services panel member that the social worker was working with the family for one month only at the time of Alsami's sad death. Therefore, the Social Worker would not have had the opportunity to build a trusted relationship with him to work on trauma. As in many Local Authorities, there can be a high turnover of Social Work staff, it is important that services consider how to work in a trauma informed manner with children that they have recently started to support. Children's Services has a process in place whereby a referral that requires longer term involvement is referred directly to the safeguarding team to provide longer term social work.

6.6 Theme: Purposeful parental engagement with safeguarding processes is limited.

Alsami's mother and stepfather engaged with professionals when they became concerned that their children were likely to be removed from their care. Once engagement was voluntary, they did not engage with Edge of Care Team nor the Child in Need plan. It is important that professionals review whether the engagement is purposeful and significantly whether the intervention is having a positive impact and outcome on the children in the family.

Alsami's mother was the main carer, and her pattern of engagement was intermittent and therefore would have impacted on all her children. When Alsami's mother did not engage in Edge of Care Team , a more immediate response would have been appropriate. A safety plan was put in place for Alsami's brother and an educational outreach worker for both Alsami and his brother. These were declined by Alsami's mother. This was a missed opportunity, especially given the history of abuse and emotional neglect in the family. Alsami's mother felt that this non engagement was due to the response she sometimes received from professionals about her request for practical support.

A strategy discussion could have been reconvened or a more robust intervention to ensure that there are consequences for lack of engagement with a plan. The professionals working with the family differed in their views about what should happen next. The social worker had assessed that the work with the family should be escalated to an initial child protection

conference. However, managers assessed that the social worker should continue to work with Alsami's mother and stepfather to consider how they respond to the Child in Need plan before escalating to a Child Protection Plan. The final outcome of the Child and Family Assessment had not been concluded at the time that sadly Alsami took his own life.

Wandsworth has a process in place where if there are differences of opinion about threshold, outcome of safeguarding processes, Quality Assurance colleagues can be consulted. A consultation with Quality Assurance would have been useful to consider the need for an ICPC but this was not sought. Whilst the decision to hold an ICPC remains with the operational manager this may have provided reflective discussion to explore the level of intervention and support. This is a learning point for children's social care about escalation at the point of increased risk and engagement from parents. This has been acknowledged as an opportunity to learn by Children's Social Care.

Alsami's family dynamics, history of abuse and emotional neglect highlight the need for professionals and the partnership to consider the learning from this review in a more holistic manner. The inclusion of all children in this LCSPR would have provided a broader perspective on the impact of abuse and emotional neglect on all the brothers and sisters.

Alsami did not have contact with his birth father since 2016. His relationship with his stepfather was described as good. However, it is also known that his stepfather was not a hands-on father. From the information available within the family, he was perceived as the child who needed more attention. The reviews carried out by professionals suggest that this did not happen.

Since 2016 and after the family moved away from Alsami's birth father, there were further three referrals to Children's Social Care which were progressed to completion of a Child and Family assessments. In 2016, when there were allegations that Alsami's father had sexually abused his six-year-old sister, there were no concerns identified for Alsami in his health, safety, or education. The following year another referral was made relating to Alsami's sister being missing from home. This referral led to completion of a Child and Family assessment. The assessment reported that Alsami was fine at home and was enjoying school. The assessment concluded that there were no safeguarding concerns, and the case was closed to Children's Social Care.

Another assessment was completed in April 2017 following an incident of physical violence towards Alsami's sister by his mother. The assessment recorded that Alsami, aged 10 at the time was seen and there were no concerns of harm towards him. Following the assessment, the case was closed in May 2017. There were no other referrals until January 2020. Between January 2020 until May 2021, there were eight contacts and referrals to Children's Social Care. One of the referrals led to Section 47 enquiries. These concerns related to Alsami's brothers and sisters. There were no indicators or concerns relating to Alsami.

Children's Social Care were involved intermittently in most of Alsami's childhood. The response to this work appears to be based on individual incidents rather than a thorough assessment about the pattern of abuse, neglect to the children including Alsami. The individual responses to missing episodes, incidents of physical violence and emotional abuse required

further professional curiosity. A thorough assessment, plan, and review of the impact of this on Alsami and his brothers and sisters would have improved practice. There is also a question about the application of threshold in the Section 47 enquiries prior to the sad death of Alsami. The request for an Initial Child Protection Conference could have been progressed while the assessment was being completed.

It is apparent that when there is a long history of children's social care involvement, with incident-based completion of assessments that resulted in no further action. Further reflection and challenge are required to consider the pattern of long-term abuse and its impact on each child in large families.

The assessments have highlighted that Alsami was seen and reported that he was fine and that he enjoyed school. Assessments require a deeper relationship-based work with each child and the impact of the emotional neglect and abuse on them. Children's Social Care have reported that they have moved to a relationship-based approach to practice across the last year.

6.7 Theme: Understanding and assessing sexual abuse in families.

Sexual abuse is a hidden and often difficult form of abuse to evidence. Alsami's older sister had made allegations of sexual abuse against her father and the family moved out of the family home. Children's Social Care found that there were no concerns that Alsami, his brother or sisters had been sexually abused by their birth father but that they had been subjected to physical and emotional abuse. The emotional abuse will have included the impact of knowing that their father had been accused of sexual abuse towards their sister. This is particularly relevant for how Alsami and his brother may perceive masculinity.

Children disclose sexual abuse as a '*process*.' It is rare that they have language to explain the abuse they are experiencing. Verbal means could be in the form of indirect not wanting to go to the home of a perpetrator who does not live with them. In adolescents, this may present as *"withdraw, self-harm, exhibit anger, avoidance and run away or to be noticed for "being good"*. *"False allegations are rare"* (Debra Allnock Sept 2019) Identifying and responding to disclosures of child sexual abuse. Children and professionals have highlighted the importance of "*trusted relationship*" between the child and "*a reliable professional."*

Following this incident, the impact of the alleged sexual abuse on the children requires further professional curiosity. It is not possible to comment in any detail about what work was carried out with Alsami's older sister on the alleged sexual abuse. The question arises about the impact of alleged sexual abuse on the male members in the family home including Alsami.

6.8 Theme: Contextual Safeguarding.

"*Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse".* (26th October 2020 Contextual Safeguarding definition).

There has been some suggestion that contextual safeguarding may be of relevance in this review. However, the Agency Reviews and Independent Management Review responses do not provide clear evidence that this is the case. Alsami's very sad and difficult to read suicide note referred to the incidents in the family home. There is no significant reference to contextual

safeguarding in the police and education IMR to suggest that this is an issue for teenagers in the area. This is in direct contrast the information held and known by Children's Social Care about contextual risk in Wandsworth. There are established strategic and operational MACE panel and data available from Children's Services and Police that indicate that like all London Boroughs, contextual safeguarding is an on-going challenge.

Wandsworth has continued to revise and aligned its contextual offer to adolescents since 2019 and again in 2021. It has a dedicated team that supports children and young people at risk of exploitation and being missing as well as a social work team for adolescents. This is important work to safeguard children who are at risk of exploitation and being missing. Alsami's brother and sister were at risk of exploitation from the information available to the review author and this would have impacted on him as their brother. Alsami took a knife to school, Children's Services records suggest that he was threatened by a close family member and he had carried the knife to protect himself. There are differing accounts of why he had taken the knife to school. It is not possible to draw a clear conclusion about why precisely why Alsami took the knife to school.

Alsami had had two contacts with the SGH where he said he had been hurt. Potentially because of covid restrictions and pressures, there was no referral to Red Thread. This was an oversight. In order to review this issue in more detail and to gain the views of his peer and the school the Chair of the review and the author attended Alsami's school to discuss this and to gain their lived experience and concerns about contextual safeguarding.

The visit to the school by the Chair of the review and the review author suggests that for adolescents walking home from school can feel threatening. However, they did not report that they are being drawn into exploitation. This review has found that there are some contextual risks, and these were shared with the Chair of the review and the author of the review. The response of the school to contextual safeguarding is positive in that all children are asked about how often they feel safe, and measures are considered about how to respond to these. Wandsworth Children's Service has a dedicated project between Early Help and Police which focusses upon incidents close to schools which involve theft, robbery, or threats between young people. This will be of assurance to Alsami's school friends. This is a positive initiative to support adolescents to feel safe in their communities.

7. Conclusion and Recommendations.

There is an overarching theme of the intersectionality of race, sex, gender, identity, and religion; how both children and families are thought about and practice is developed, and the voices and experiences are understood by professionals. Since this review was commenced Children's Social Care have been embedding the use of Social Graces tool as part of its commitment of systemic practice and this application could be extended to the wider partnership. Along with cultural genograms the Social Graces provides an opportunity to explore and understand the identity and values important to families.

That Alsami took his own life because in his view, this would make the world a better place for his family is very difficult reading for professionals who work very hard to safeguard children. All agencies have reviewed their processes and have highlighted areas that they have changed since Alsami's tragic death. There are areas for improvement, and these have been

reviewed appropriately and recommendations have been made by each agency for changes in their approach to work with vulnerable teenagers. There are many learning points in this review, two areas that require further consideration is the rigour with which processes are employed especially at times of national crisis such as the pandemic and secondly the importance of how the child's background, sex, gender, religion, ideals about masculinity and racial demographic challenges agencies to understand and work with families in crisis. In Alsami's experience there is a need to understand the nuances of intersectionality and the many layers of identity and life experience that was Alsami's lived experience.

8. Learning Points

1. Knowing the child and his/her lived experience. This review has highlighted the importance of taking time and assertive commitment to understand the lived experience of a child.

2. Ensure that professionals are proactive in understanding and working with the religious, cultural background of children they are in contact with.

3. The impact of Adverse Childhood Experience and childhood trauma on children whether they verbalise their concerns or not.

4. Take particular care and attention towards 'sensitive and quiet' children in a large family group. Ensure that their views, worries, concerns and lived experience are sought and assertively included in plans and any work with them.

5. Purposeful parental engagement which takes account of the parental vulnerabilities, Adverse Childhood Experiences, and childhood trauma on their parenting.

6. Have an informed view about the impact of alleged sexual abuse on all children in the family and in particular male children where the perpetrator is a male and the victims are female children. Take account of research into the impact on male self-image, masculinity, and self-esteem of male abuse in families.

7. Contextual Safeguarding. Recognition of the impact of contextual safeguarding to adolescents, especially young men who may be subject of exploitation and fear in communities. The use of current processes and procedures to engage with partnership developments on contextual safeguarding. The partnership will want to develop this in its action plan.

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