Child Safeguarding Practice Review Final Report Beta

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1. Introduction

1.1 This Review has been commissioned by Staffordshire safeguarding partners, following a decision by the Staffordshire Safeguarding Children Board (SSCB) Rapid Review Group that, in Accordance with Working Together 2018[1], this case met the criteria for a Child Safeguarding Practice Review (CSPR) as abuse or neglect was suspected. Beta had suffered serious harm and there were concerns about the way agencies had worked together to keep her and her siblings safe.

1.2 The family were well known to services in Staffordshire. Beta and her siblings had been subject to Child Protection (CP) plans historically and there had been a previous Serious Case Review following the death of a sibling.

1.3 A CSPR was proposed to, and agreed by, the National Panel. This CSPR will consider the guidance in Working Together and the principles of the systems methodology recommended by the Munro review.[2]

1.4 Beta, the subject of this review, is of white British heritage. Beta is a young person who is very articulate and artistic. Beta loves Japanese comic style animation and loves to create pictures using technology. Beta likes crystals, loves her sister and is very close and protective. Beta attends the police cadets and would like to become a police officer; she likes 3D dragons which assist with her anxiety.

1.5 The following is a table of all the individuals referred to within the report:

Name	Relationship to Subject	Blood relative to subject
Beta	Subject	
Mother	Mother	Yes
Stepfather	Mothers ex-partner	No
Guardian 1	Stepgrandfather	No
Guardian 2	Stepgrandmother (mother to stepfather)	No
Sibling 1	Brother (deceased)	Yes
Sibling 2	Half sister	Yes
Cousin 1	Stepcousin	No
Cousin 2	Stepcousin	No

2. Summary of Learning Themes

2.1 The following are the main learning themes resulting from this review:

- There is a need to have a conversation around risk including, people's perception of risk, the different risk assessments, and the interface between them.

[1] HM Government (2018) Working Together to Safeguard Children https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).

- When the Local Authority contests an SGO, or there is a change in circumstances within a family unit, all partners should be informed, and a multi-agency approach taken.
- Children need to always remain the focus. Children are not currently central to processes and should be. If adults caring for children experience medical issues, grief etc, consideration should always be given to the impact on the children.
- How does the SSCB make sure all partners are aware of a family being involved in a SCR / CSPR and ensure that records reflect that?
- Building trust, providing opportunities for children to disclose, and asking the right questions at the right time, is imperative to disclosure. There is a need for honesty and for keeping children informed about what a practitioner will be doing next.
- Exhibit professional curiosity. Question everything – what if what you're being told is not true? Is there evidence to the contrary that can be explored?
- Where multiple types of abuse are taking place, give attention to each form of abuse rather than allowing one type of abuse to overshadow the other.

3. Context of Child Safeguarding Practice Reviews

3.1 The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel and at local level with the safeguarding partners. The purpose of the review is to identify improvements to be made to safeguard and promote the welfare of children. Locally, safeguarding partners must identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. 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.

3.2 This review will:

- provide a way of looking at and analysing frontline practice as well as organisational structures and learning.
- reflect the child's perspective and the family context.
- be proportionate to the circumstances of the case.
- focus on potential learning, and
- establish and explain the reasons why the events occurred as they did.

4. Succinct summary of case

4.1 Beta was previously known to children safeguarding services and early help (EH) services in Staffordshire from 2012. Beta and her siblings were subject to child protection plans on two occasions spanning 4 years under the category of neglect. Concerns included very poor home conditions, lack of food, domestic violence, adult mental health issues, lack of parental supervision, disguised compliance and non-compliance with professionals and regular presence of persons who present a

risk to children[3] (PPRCs) in the home. Beta's stepfather had a historic conviction for a sexual offence against a male child. Stepfather was 17 at the time of his offences and for that reason he was placed on the sex offenders register for a period of 2.5 years, following which he was removed from the register and classified as an unregistered sex offender.

4.2 Beta's sibling, sibling 1, died due to neglect. Mother was subsequently found guilty of cruelty to, or neglect of children and stepfather was found guilty of manslaughter by gross negligence and sentenced to 90 months in prison; he was released after 39 months. A Serious Case Review was conducted.

4.3 Beta and her half sibling, sibling 2, were placed with stepgrandfather and stepgrandmother who later applied for a Special Guardianship Order[4] (SGO). The reviewer was informed by practitioners that the couple had indicated that securing care of sibling 2 was their primary focus. Children's Social Care (CSC) following assessment recommended adoption for sibling 2 and a Child Arrangement Order[5] for Beta. The Court granted an SGO to stepgrandfather and stepgrandmother (hereafter known as Guardian 1 and Guardian 2) along with a 12-month supervision order; the local authority viability assessment was negative.

4.4 In September 2018 Guardian 2 died. Although a referral was made to CSC at the time of her death, this did not lead to a review of the SGO or re-assessment of Guardian 1 ability to becoming the sole carer for the children. The children remained in sole care of Guardian 1. Guardian 1 was also caring for two other stepchildren (cousin 1 and cousin 2) at that time. Guardian 1 had his own health issues including unresolved Post Traumatic Stress Disorder (PTSD) type symptoms, including a stammer (which increased with anxiety and was a source of frustration), poor physical health, diabetes and depression and was struggling financially. A referral was made to the Early Help Team (EHT) to provide support to him. CSC would have done an EH assessment but whilst the EHT worker was going in the home, Guardian 1 refused the formal assessment.

4.5 The Community Mental Health Nurse was going to look at the impact of trauma therapy and Guardian 1 was re-referred to the GP to increase his anti-depressants.

4.6 A few months later when the referred issues had been addressed the case was closed. No concerns were identified for the children when presented for health appointments.

4.7 Further contacts to CSC were made during 2019 and 2020 with regards to concerns about risky adults visiting the home who were previously known to the children, funding arrangements under the SGO, and concerns from mother's sister that stepfather was having telephone contact with her daughter cousin 2. Stepfather was still in prison at this point. All of this resulted in the team offering advice only; no further action was taken by the local authority.

4.8 The probation service informed CSC of stepfather's imminent release. Stepfather was released to approved premises[6] in Birmingham with conditions attached to his

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[3] PPRC – Formerly known as a Schedule One offender – a person convicted of one of the crimes listed in the Children and Young Persons Act 1933. However, the term Schedule One offender has now been replaced with the term 'person posing a risk to children'.

[4] Special Guardianship is an order made by the Family Court that places a child or young person to live with someone other than their parent(s) on a long-term basis. Adoption and Children Act 2002

[5] A Child Arrangements Order is a legal order where the court decides either where a child will live or who a child can spend time with and for how long.

[6] Approved Premises (APs) are premises approved under Section 13 of the Offender Management Act 2007. They provide intensive supervision for those who present a high or very high risk of serious harm.

licence which meant he had a curfew, had to disclose any new relationships, as well as any contact with children, which would have had to have been pre-approved by the offender manager. It came to light stepfather had been able to have telephone contact with all the children in the household whilst in prison.

4.9 Following his release in March 2021, and with CSC's knowledge, stepfather resurrected his relationship with the family. He was known to be having video and face to face contact with the children at Guardian 1 home address; Guardian 1 was required to supervise this contact.

4.10 There is some evidence suggesting Guardian 1 might have been deceiving professionals. Stepfather informed probation of a change in Beta, saying she was becoming more distant and appeared to be overwhelmed with the contact, not just with stepfather but with others too. Stepfather agreed to only visit Beta when she asked. Further to Beta's increasing anxiety, stepfather reported a reduction in visits to every fortnight but later indicated he has not seen the children and was waiting for them to make contact. It appears that stepfather was having contact with many children in the wider family, in part because he started an intimate relationship with his stepbrother's half-sister.

4.11 Beta disclosed sexual abuse by stepfather, he was recalled back to prison. During her Achieving Best Evidence[7] (ABE) interview Beta disclosed that since stepfather resumed contact in March 2021, he had abused her on more than one occasion; she indicated the abuse had started before he went to prison. This was not known during the previous SCR.

5. Methodology

5.1 Following notification of the circumstances of Beta's case, and agreement by the SSCB partners to undertake a Child Safeguarding Practice Review, the Review Panel was established. A reviewer/chair, Nicki Walker-Hall, was commissioned by SSCB. An initial set up meeting was held, and the following methodology agreed.

5.2 The single agency chronologies provided for the Rapid Review were merged and used to produce an interagency chronology. This was analysed by the reviewer and the panel members who developed hypotheses, to further inform the Key Lines of Enquiry for exploration and consideration.

5.3 Each agency was required to complete a learning summary report focussing on the Key Lines of Enquiry, providing analysis, and identifying single agency learning. It was agreed the review would examine in its entirety the period from 14-09-2018 until the 18-06-2021.

5.4 A summary of any significant incident/s the author deems relevant to the case was to be included, if it was believed that additional learning could be extracted or if the event pertained to the key focus points.

5.5 Key practitioners were identified and asked to attend a practitioner's event. The event provided an opportunity for the partnership to consider the potential systemic issues identified through the individual agency reports. This event

[7] ABE - covers the interview process for child and adult victims and witnesses during a criminal investigation, the pre-trial preparation process and the support available to witnesses in court. The interview guidance set out in ABE includes video-recorded interviews with vulnerable and intimidated witnesses where the recording is intended to be played as evidence-in-chief in court. ABE promotes a strong victim-centred and trauma-informed approach throughout the guidance. https://www.gov.uk/government/publications/achieving-best-evidence-in-criminal-proceedings

focussed on the subject's journey through the system in order to reflect on and share learning and, to identify opportunities for improved working within and between agencies in the future.

5.6 The 3-hour event involved practitioners from across health and the police and was facilitated by the reviewer. There were no local authority attendees, all SW's involved in the case either no longer work for the authority or were unavailable. The reviewer has had an opportunity to discuss the case from a SW perspective with the assistant manager in post at the time, and another who knew the case and family well.

5.7 The reviewer spoke with Beta to gain an understanding of her experience of practitioners and the services they provided.

5.8 The reviewer completed a draft report which was analysed by the panel. Partner organisations via the panel were provided an opportunity to agree actions to address the blockages and barriers identified. The panel considered the most appropriate method to share the learning across the workforce in Staffordshire.

5.9 Whilst it is intended learning from the full report will be made available to the public, the decision regarding publication of the full report will be made only following consideration by the partnership.

6. Limitations

6.1 There have been some limitations to the review. Not all invitees attended the practitioner's event. Not all the young people within the household have been spoken to. One declined involvement due to concentrating on exams, another was felt to be too young.

7. Key Lines of Enquiry

7.1 The following Key Lines of Enquiry were agreed:

1. Examine the quality of decision making and assessment:
    - regarding the SGO following Guardian 2's death
    - within the first response team
    - around the arrangements for contact with the children following stepfather's release from prison, along with the on-going assessment of risk given that stepfather 1 has previously admitted adults with PPRC status were entering the home under his supervision.
    - by the courts at the time the SGO was agreed
2. Consider what led to the lack of exploration of stepfather 1's motivation throughout, but specifically at the point of his wife's death and latterly wishing to secure an SGO for Cousin 1 and cousin 2.
3. Explore if/how agencies had no knowledge of the relationship between this child and the adult, all of whom were subject to the previous SCR.
4. Consider how collectively the partners have not been able to prevent stepfather from re-offending, and whether there were missed opportunities to protect Beta at various points prior to Beta disclosing.
5. Consider whether the SGO is a legal failure or an operational/ practice failure?
6. Examine the voice of the child considering Guardian 1 behaviour, and whether this was seen through the eyes of the children. Why was their voice rarely heard, other than by the two schools?

7. Explore how practitioners formed their view of Guardian 1 and his ability to keep the children safe, both during the time stepfather was in prison where the children should have had no contact, and upon release. Consider how easy it was for stepfather to manipulate others over the phone, and how was this seen, should this have alerted professionals more so because of Covid-19?

An additional line of enquiry will be looked at via a separate meeting and will consider:

8. The decision making around the key lines of enquiry used in the previous Serious Case Review. This meeting will concentrate on decision making around PPRC's.

8. Engagement with family

8.1 The reviewer met with Beta to gain an understanding of her interactions with professionals and her experiences of the services provided. The reviewer is grateful to her for her willingness to help others through her reflections. The reviewer met with Beta on two further occasions, to provide an opportunity for Beta to shape the content of the report and understand the learning to be shared. Beta expressed a wish for the full report to be published to help others. Extensive efforts have been made to include other members of the family in the review unfortunately these have not proved successful.

9. Review team

9.1 The Review Team consisted of the reviewer, Nicki Walker-Hall, and members of the SSCB Review Subgroup, which included senior safeguarding representatives from the following agencies:

- CSC
- Education
- Police
- Probation
- CCG
- MPFT
- CAFCASS
- SSCB Business Manager

Nicki has worked in safeguarding roles for over twenty years. Nicki has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki is an experienced author of both children and adult safeguarding reviews; she has a background in health.

10. Timescales

10.1 Working Together to Safeguard Children 2018 states that a review should be completed and published within 6 months from the date of the decision to initiate a review. Given that there are other proceedings which have had an impact on publication, for example an ongoing criminal investigation, the safeguarding partners will agree a date for publication once these proceedings have concluded.

Analysis pertaining to the Key Lines of Enquiry

11.1 Partner's ability to prevent stepfather re-offending, protect Beta and not rely on self-disclosure

11.1.1 Before Beta's siblings' death, professionals understood that stepfather had PPRC status relating to a sexual offence but lacked understanding regarding what level of risk he posed. During that time, mother was supervising stepfather's contact with the children. Stepfather was classed as a medium risk[8] and was not allowed any unsupervised contact with the children (stepfather was living with the children at the time). Stepfather was being managed by the Community Rehabilitation Company (CRC).

11.1.2 Stepfather was then convicted for manslaughter and, following his time in prison he was managed by Probation. Probation have rightly identified lots of positive practice taken by practitioners around monitoring and trying to help reduce the likelihood of stepfather offending. However, stepfather was manipulative and non-compliant with restrictions which is not uncommon. Whilst offenders are stringently monitored, probation can't stop someone from re-offending if that is their intention, but they do recall offenders back to prison immediately if a further offence is suspected or proven.

11.1.3 Following Beta's siblings' death stepfather was assessed as a high risk[9] to children due to his manslaughter conviction and not because of his historical sexual offences. In part due to stepfather's young age at the time of the sexual offences he was, by that time, an unregistered sex offender[10]. This was not widely understood by all agencies and created much confusion.

11.1.4 Stepfather's PPRC status was accurately communicated to the prison, and he was to have no contact with children (level 1). This was then stepped down whilst stepfather was incarcerated to written contact only (level2); the rationale is not understood and is contrary to the conditions of his sentencing. Under level 2 there should still have been no telephone contact with, or visits from, children.

11.1.5 It later transpired that stepfather had been having some contact with Beta via telephone. Beta indicated she had wanted telephone contact with stepfather as" he was my dad" and had never been, or felt, forced into the contact. As telephone contact had not been agreed stepfather's telephone calls were not being monitored thus providing an opportunity for stepfather to groom Beta.

11.1.6 Because stepfather was an unregistered sex offender, he was not subject to the same assessment and monitoring as a registered sex offender. Stepfather was not assigned a named police public protection officer to assess his level of risk of recidivism as would be the case for a registered sex offender. As a result of no assessment being required, whilst static risks such as age at first offence, sex of victim, and criminal record were all well known what was not known were any dynamic risk factors as a result of changes in circumstance. This is likely to be the

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[8] Medium: there are identifiable indicators of serious harm. The offender has the potential to cause. such harm, but is unlikely to do so unless there is a change in circumstances

[9] High: identifiable indicators of risk of serious harm. The potential event could occur at any time and would be serious
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1060610/Risk_of_Serious_Harm_Guidance_March_2022.pdf

[10] The length of time an individual must remain on the sex offenders register will depend on the offence which they have committed, and the sentence passed.

reason why professionals were consistently seeking clarity on the level of risk he posed.

Learning point 1: A lack of understanding by the receiving agency regarding stepfather's PPRC status and the level of risk he posed in relation to sexual offending, coupled with his non-adherence to conditions of sentencing in relation to his contact with children (which was not shared with or known to the probation service), left Beta and potentially other children vulnerable to grooming whilst stepfather was incarcerated.

11.1.7 Probation, in line with procedure, notified CSC of stepfather's imminent release. The reviewer learned that the format and content of the PPRC notification form is somewhat limited and does not assist receiving practitioners to understand what they need to do with the information it contains. CSC assured probation that adequate safeguarding was in place through another adult supervising all contact. That assurance was accepted and, in the absence of any conflicting evidence, was not challenged. Because CSC were assured Guardian 1 was able to supervise contact between stepfather and the children, probations notification of release did not lead to a multi-agency meeting (either CP or CIN) to fully explore how the children within the family would be kept safe.

11.1.8 There is no requirement for Probation to inform other services involved with the children of an offender's release, thus they were not formally made aware. School was made aware by Guardian 1 that stepfather was to be released. Guardian 1 reported he would be supervising all contact; confirmation was sought by school from CSC who corroborated this information.

11.1.9 An anonymous referral regarding another known PPRC visiting the family home resulted in no further action. Guardian 1 was contacted by telephone and indicated that he would strictly supervise all contact if this man was to visit the home again. Practitioners trusted that this was the case however, it is of concern that this man was allowed into the home in the first place, and there does not appear to have been consideration of Guardian 1 lack of judgement regarding this, or wider thinking of whether this affected thinking regarding whether Guardian 1 would be compliant with a request not to have a PPRC back in his home.

11.1.10 When partner agencies contacted CSC, they were informed stepfather presented a low risk of serious harm to children; it is not clear how CSC had come to that conclusion, or what risk assessment tool they had used. However, what is known is that stepfather had advised CSC that he had been having telephone conversations with the children whilst in prison. The fact that he had already been having contact with the children, a lack of clear understanding around the conditions of his sentencing, coupled with Guardian 1 assurance that he would supervise all contact, appears to have lulled CSC practitioners into a false sense of security. There appears to be a lack of understanding, and differences in professional's interpretation, of direct and indirect contact. It is also possible that professionals were themselves being groomed or deceived.

11.1.11 The SGO gave some practitioners a false sense that everything must be ok. Had sufficient thought been given to Guardian 1 belief that stepfather had served his time and therefore he posed no risk, practitioners might have taken a different view.

11.1.12 Upon release, stepfather was staying in Approved Premises. These premises are for high-risk offenders; this was not known to practitioners working with the children. Stepfather had a license condition that he was to have no unauthorised contact with children and was to disclose any new relationships.

11.1.13 Stepfather did discuss his contact with the children, giving some information to probation staff regarding the children's reactions to him, which in retrospect appears highly suspicious. This was not referred to CSC.

11.1.14 Stepfather portrayed himself as a victim and didn't take responsibility for his offending. He tried to evoke sympathy from professionals; it is possible that the same dynamic occurred between stepfather and Guardian 1.

11.1.15 Although information regarding the children having a stepfather known to have a PPRC status was held within both Beta and sibling 2's GP records, not everyone had access to this, and for those that did, it was not easily accessible. PPRC status wasn't highlighted on the children's records as a cause for concern. The information did not appear on stepfather's records and was therefore lost.

11.1.16 When Beta disclosed abuse the probation service recalled stepfather back to prison.

Learning point 2: Systems and processes around notifications of release and PPRC status are not providing the level of clarity, to those receiving the information, regarding the level of risk posed by offenders. Practitioners need to be curious when they receive information to ensure they understand what they are being told and what is to happen next. There is inconsistency in how agencies have assessed and are recording the risks. There is potential for the PPRC status of those committing offences as young people to be lost. There was some confusion about what 'medium risk' looked like for Probation and what was meant by direct and indirect contact as well as confusion about the terms 'sex offender status' and 'PPRC', and what this meant for managing risk. Lack of understanding regarding PPRC is not a new finding in Staffordshire; this was highlighted in a previous thematic review. The probation service is currently putting together a briefing outlining probations powers and licensing conditions to increase the partnerships understanding. Issues that should have been seen as red flags to practitioners were not given sufficient consideration in the context of what was known of the family. Professional curiosity was not exhibited even though this was a family who were well known to have contact with a number of PPRCs. Considering this it would be reasonable to expect any referral in these circumstances, suggesting on-going contact with a PPRC, should have led to thorough investigation.

11.2 The granting of the Special Guardianship Order (SGO) in relation to Beta and sibling 2

11.2.1 Beta was removed from the care of mother and stepfather following the death of sibling 1. Beta and sibling 2 were placed temporarily with Guardian 1 and Guardian 2. This arrangement became permanent following the court granting an SGO. Prior to this CSC conducted a Full Connected Persons (FCP) assessment[11]. Concerns were

[11] If a Local Authority is responsible for accommodating a child, the child acquires 'looked after' status and as such The Care Planning, Placement and Case Review (England) Regulations 2010 require that the Local Authority satisfy itself that any placement into which the child is accommodated is appropriate, safeguards and promotes the child's welfare and meets the child's needs. If the Local Authority is proposing to place a

raised about the implications for the placement based on the fact that Guardian 1 and Guardian 2 had no biological relationship with Beta, and Guardian 2 did not duly acknowledge the seriousness of stepfather's prior sexual offending. The FCP assessment concluded negative with an outcome that Guardian 1 and Guardian 2 would not meet National Minimum Standards (2011) for foster carers and therefore their application for Special Guardianship was not supported by CSC. In addition, the appointed children's guardian[12] did not support the SGO.

11.2.2 The CSC sought a CAO and SO for Beta and adoption for sibling 2 but the court over-ruled this.

11.2.3 The author is aware that whilst the CSC viability assessment was negative, Beta expressed a wish to remain in the care of Guardian 1 and Guardian 2. Guardian 2 was an intervenor in the court proceedings and present throughout; Guardian 1 did not take an active part. The case was heard over a week and was reported to be a very difficult case with a very long judgement. The Family Court, based on all the presented information, granted an SGO in respect of Beta and sibling 2 to remain in the care of Guardian 1 and Guardian 2 and, unusually, made a 12-month Supervision Order.[13] The children's guardian did contest the decision in respect of sibling 2 but not Beta. The judge indicated further review may be needed at the end of this period to consider whether a further period of supervision and support may be required. The author understands that the children's guardian was not unhappy with the final judgement. Due to lack of engagement by the courts in the CSPR process, it has not been possible to explore the rationale for the decisions further. Despite some movement to facilitate the involvement of the judiciary service in reviews, and the Presidents Guidance regarding Judicial Cooperation with Serious Case Reviews (2017), [14]this guidance is now out of date and lack of involvement by the judiciary continues to be a national issue.

Learning point 3: Lack of readiness by the judiciary to support and share proportionate information for this Child Safeguarding Practice Review, has been a limiting factor in fully analysing this KLOE. This finding is of national importance.

11.2.4 Partner agencies were unaware of the Supervision Order, and indicated that had they been aware of it, the case would have been managed in CIN. The lack of information sharing around the Supervision Order and subsequent lack of a multi-agency approach was contrary to procedures and a missed opportunity.

Learning point 4: Following the court issuing a supervision order in addition to the SGO, all involved agencies should have been made aware, the case discussed in a Supervision Order planning meeting and the SGO support plan reviewed.

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child in the care of a 'connected person', an assessment is required to determine whether that placement is consistent with the requirements of the above Regulations.
If the child is 'looked after' by the Local Authority full assessment of the 'connected person' will need to satisfy the requirements of The Fostering Services Regulations 2002.

[12] The role of Cafcass – the role of the Children's Guardian | Cafcass

[13] A Supervision Order imposes a duty on the local authority to 'advise, assist and befriend' the child.

[14] https://www.judiciary.uk/wp-content/uploads/2017/05/pfd-guidance-judicial-cooperation-with-scrs.pdf

11.2.5 When Guardian 2 died Guardian 1 notified CSC's Family and Friends team the same day. Regulation 17[15] requires that where the local authority provides special guardianship support services for a person, it must review the provision of such services if any change in the person's circumstances which may affect the provision of special guardianship support services comes to their notice. At that time there was no procedure informing staff what to do in such circumstances.

11.2.6 The First Response Team (FRT) contacted the Team Manager of the Family and Friends Team (F&F) who agreed to contact Guardian 1 and explore support. The First Response worker (FRW) updated the Assistant Director (AD) of the plan to close the referral as support would be offered by F&F team. It is documented that the AD had checked with legal services whom the SGO was made to, as if only Guardian 2, there would be matters of parental responsibility to address. It was confirmed that the SGO was made to both Guardian 1 and Guardian 2, therefore Guardian 1 retained parental responsibility for both children. Agreement had been given by managers and the AD for support to be offered via the Early Help Team. A referral was made to the Early Help Service (LST) to provide support to Guardian 1.

11.2.7 Whilst these actions were taken internally there was no formal notification to partner agencies who learned of Guardian 2 death via Guardian 1 in the following weeks. The lack of notification meant that any immediate opportunity to consider the impact of Guardian 2 death on a multi-agency basis was lost.

Learning point 5: The lack of a procedure covering the change in circumstance of those awarded an SGO proved problematic. Frontline practitioners rightly sought the advice of their managers. The focus was on support for the family; there was no decision to re assess the SGO made previously. Managers made a specific note that practitioners needed to be mindful of the emotional impact of Guardian 2 death upon the family. The reviewer has considered the draft procedure and suggests the procedure be more explicit regarding the requirement for reassessment in all cases where the Local authority was not supportive of the original order.

11.2.8 Full consideration as to whether Guardian 1 could adequately keep safe and care for all four children in his care was required via an assessment. However, practitioners were impeded as Guardian 1 did not consent to an Early Help Assessment. Consideration should have been given at this point for internal step up to the safeguarding team on the basis that Guardian 1 had refused consent for assessment. This was a missed opportunity to review risks and analyse his care.

11.2.9 Guardian 1 attended the GP at this time, and it was noted he was struggling. A referral was made to CSC. The GP was informed the Early Help Service were visiting him that day and would support him.

11.2.10 Guardian 1 said he would kill himself on two occasions in the weeks following Guardian 2 death. Police officers attended on both occasions, on the first occasion they spoke to the SW directly and on the second, they submitted a Multi-Agency Referral Form and allocated a Local Neighbourhood Officer. No formal written assessment was undertaken from the EHT, nor was the level of Guardian 1 mental health, and the effect of such upon the children, and his ability to care, considered. Of note Guardian 1 mental health is detailed within the SGO assessments from 2017 (deemed negative). The information around his mental health was considered

[15] Regulation 17 - Special Guardianship Regulations 2005

from a position of grief, rather than within the wider context of his caring responsibilities.

Learning point 6: Whilst it is entirely appropriate for professionals to be empathetic and supportive of a bereaved guardian, whenever a guardian appointed through an SGO dies a multi-agency response and review of the suitability of their remaining guardian must take place. Guardian 1 was seen as someone doing his best for the children and this appears to have allowed a more relaxed approach when concerns were raised.

11.3 Guardian 1 motivation for wanting to secure an SGO for cousin's 1 and 2.

11.3.1 Guardian 1 motivation for wanting to secure an SGO for cousin 1 and cousin 2 is not fully known; it appeared to CSC that his motivation may in part be financial. There was much confusion amongst professionals regarding his financial situation. Guardian 1 consistently indicated he had no money to his GP however CSC believed he gave his money to the children.

11.3.2 Beta informed the reviewer that following Guardian 2 death Guardian 1 struggled financially and described the state of the home as going from "modern day to old". Beta indicated Guardian 1 got "a bit of money from someone" which they used to do the house up. Beta indicated the children received money from their parents which they saved and would choose to give that money to Guardian 1 to help out; "they fixed the house and got a new back garden".

11.3.3 An assessment undertaken by the safeguarding team in March 2020 when Guardian 1 sought an SGO in respect of cousin 1 and cousin 2 concluded No Further Action (NFA), it does not appear Guardian 1 financial situation was fully explored. CSC were of the opinion that he should seek to obtain a private SGO. Guardian 1 did not agree and indicated he had not received any of the promised help or support over twelve years.

11.3.4 School informed the reviewer that Guardian 1 had indicated he wanted an SGO in place to give him parental responsibility, citing issues in gaining permission to obtain passports for the children. If that was his motivation a Child Arrangement Order (CAO) would have been sufficient.

11.3.5 In July 2020, cousin 1 and cousin 2's mum indicated she had concerns about stepfather wanting contact with the children upon his release. Because CSC were not involved in the SGO application it is not known whether this was considered as part of the application.

11.3.6 There was an opportunity to consider Guardian 1 motivation to secure an SGO when he attended the GP with sibling 2 in June 2019, and again in December 2020 when it is recorded that Guardian 1 had applied for special guardianship for 2 other children. Guardian 1 was being provided with a sick note during this period due to anxiety and depression therefore a contextual assessment e.g. 'Think Family'[16] at this time may have been identified whether there were any concerns about him being a sole carer for 4 children.

[16] Think Family aims to secure better outcomes for adults, children, and families by coordinating the support and delivery of services from all organisations and promoting the importance of a whole-family approach.

Learning point 7: Practitioners concentrated on supporting Guardian 1 and the family. Wider thinking as to whether Guardian 1was capable of looking after all the children, and his motivation for securing an SGO, were never explored but had been viewed by practitioners as coming from a good place. There is no evidence to suggest Guardian 1 motivation in obtaining SGOs for the children was considered untoward or suspicious.

11.4 Explore if/how agencies lacked knowledge of the relationship between Beta and the adults, who were subject to a previous SCR.

11.4.1 Over time not all practitioners or agencies working with the family were aware of the relationship between Beta and stepfather. Stepfather was not Beta's biological father and due to the way and where information was recorded, the connection to his previous conviction, was lost. When Guardian 2 and Guardian 1 were granted the SGO for Beta, whilst CSC knew, this was not known within all partner agencies; there was nothing on their internal records to indicate any relation to the SCR for Beta's sibling. Following referrals to CSC it was in the main only Guardian 1 view that was sought; therefore, practitioners were not in receipt of a full picture.

11.4.2 During Guardian 1 conversations with practitioners, he spoke about the family dynamics and specific family members contact with the family unit. He could choose to tell what he wanted, this was his narrative, and no evidence was sought either way to test if what he was saying was true or not. Guardian 1's narrative was one of poor relationships in particular with mother, but refers to Guardian 2, and others (including a known PPRC), in a positive light.

11.4.3 The lack of assessment following Guardian 2's death meant that any change in family dynamics or family time was not considered within a wider picture. Practitioners' perception was that everything was alright.

Learning point 8: It is vital that important historical information is recorded within client's records and professionals apply critical thinking to ensuring the connections are made when children are involved in reviews. At the time this review was commissioned, there was no process across the partnership to ensure that connections to a previous or ongoing review were in place. Had this information been available at the time, when stepfather was released from prison it could have triggered wider, critical thinking from partners as to whether there was the need for an assessment.

11.5 Consider whether the SGO in respect of Beta was a legal failure or an operational/ practice failure.

11.5.1 It should be noted that most SGOs are positive and provide permanency for children however, in this case, particularly when circumstances changed, it was not.

11.5.2 When considering whether the SGO was a legal failure in this case the author was informed that the courts were provided with the assessment completed by CSC. During the hearing Guardian 2 acted as an intervenor within the court. Beta had expressed a wish to remain in the care of Guardian 2 and Guardian 1. Guardian 1 was not present, as sibling 2 was very young and he was taking care of her at home, therefore his views were not heard within court.

11.5.3 The reviewer has not had access to the transcript of the proceedings and is therefore not aware whether the couple's views on stepfather's imprisonment for historic

sexual offences were discussed, or whether appropriate guidance was given regarding contact arrangements. The courts in addition to the SGO issued a 12-month supervision order[17], suggesting that the court deemed there was a need to have some initial oversight of the children by social services. The reviewer cannot therefore conclude that there was legal failure.

11.5.4 Following the success in obtaining an SGO, there was no formal notification to all the agencies offering a service to the children, and there are various recordings of what this means. Some practitioners have on record that Guardian 1 had parental responsibility, others record that Guardian 2 and Guardian 1 are the parents.

11.5.5 In general, it is not clear whether GPs fully understand the legal association with SGO, and equivalent family arrangements, when care is transferred to other family members. GPs record parental responsibility in many ways. There is the option to apply an SGO code and identify who has parental responsibility on the child's records but not the adults; there is the option to code the adult as a guardian. There is a place to add some narrative next to a code but there isn't a facility to connect families on the records. On the most widely used GP system in Staffordshire there is no ability to see family or household relationships. Coding of records is a national issue. Currently the Royal College of GPs and NHS England Safeguarding are conducting a review of coding.

11.5.6 When the SGO was granted, this didn't mean that all the concerns expressed by CSC were unwarranted, it just meant that having listened to all the presenting arguments it was felt the best option for the children. The practice failure is around what happened next in terms of the supervision order, management of the ongoing concerns and actions taken when new concerns were identified. Following the court issuing a 12-month supervision order there was no formal notification of this to all the agencies offering a service to the children. Beta indicated frequent visits from CSC during this time but was unaware why. MPFT indicated that had they been aware the case would have been managed as CIN.

11.5.7 The SGO seemed to offer a false reassurance to practitioners that everything in the family was and would remain alright. Practitioners have demonstrated a lack of understanding regarding SGO and appear to be under the impression that an SGO brings with it an oversight of the family. Whilst this is true of the supervision order this is not the case with an SGO. There is nothing to prevent a child who lives with a person who has been awarded an SGO also being subject to Child in Need/Child Protection processes if and when concerns arise.

11.5.8 The primary school did contact social services in November 2020 when it had concerns about sibling 2's cleanliness and presentation. This was a missed opportunity for CSC to conduct an assessment.

Learning point 9: There is a general lack of understanding around legal orders; in this case SGOs and supervision orders. There is no robust process for informing partner agencies of a successful application for an SGO at point of issue, or information sharing around what that means in terms of the child's living arrangement and changes to parental responsibility. There is no agreed format for

[17] A supervision order is a legal order, obtained by the local authority through the court, which requires a child to be supervised by social services, while still living in the family home (or placed with a relative), to make sure that the child is well cared for.

recording when legal orders have been made and currently there is no narrative in the GP records when someone is coded as a guardian.

11.6 Voice of the Child - Why were the children's voices rarely heard.

11.6.1 Very few Agencies/practitioners had any meaningful contact with the children. Following contact with CSC and the Police on two occasions following Guardian 1's threats to take his own life there was opportunity to talk to the children. No one from CSC front door spoke to the children on the first occasion. However, the children were spoken to by the EHW both when they attended a Teen Aspire Group and when she visited their home. It is recorded that the Police Officer in attendance on the second occasion spoke with the children; the only comment they were said to have made was they were being picked on regarding the death of their brother sibling 1. Beta has no recollection of being spoken to by a police officer at any time. The children were seen by a SW alone once at that time.

11.6.2 Probation had no contact with the children. Despite this, some individuals involved seemed to accept stepfather's portrayal of himself as concerned and supportive and, assumed there were positives in his relationship with the children without evidence from the children.

11.6.3 Although initial health assessments were completed when Beta first became Looked After in 2016 there is no evidence of any health assessments in the children's records during the review period. This is likely due to the fact that health assessments are not required once children become subject to an SGO. Health assessments provide a good opportunity for children's voices to be heard.

11.6.4 There was very little contact with the GP as the children required infrequent visits. GP records for those visits do not demonstrate that their voices have been heard. Guardian 1 contacted the GP regarding cousin 2. Guardian 1 indicated cousin 2 had symptoms suggestive of cystitis for a few days. Whilst this is deemed a common condition, this can also be indicative of sexual activity and an opportunity was afforded for this to be explored further through discussions with the child. Cousin 2 was seen face to face later that day by a female GP, providing a potential opportunity for cousin 2 to say if she was being abused and for the GP to ask. However, it is not clear whether cousin 2 was on her own or accompanied when she was examined, and nothing was identified during examination to suggest any further exploration was required by the GP.

11.6.5 Of note, changes to the way people are accessing health care means there will be less face to face contact which will inhibit GPs abilities to talk to the child directly.

11.6.6 The children were all well supported in school, Beta spoke about sibling 1 and all the children would talk about Guardian 2; they did not openly talk about stepfather or Guardian 1.

11.6.7 Practitioners indicated there was nothing in Beta's presentation that alerted them to any abuse which raises the question what does an abused child look like? Practitioners need to be mindful not to have a stereotypical view of what an abused child may look like or how they may present. Many resilient children will not give major indicators that they are being abused and many children will do what Beta indicated she had done "boxed off the abuse. "It is therefore imperative that practitioners explore every unusual event/behaviour/piece of information.

11.6.8 Comments made by stepfather indicating he was "no longer sleeping in Beta's room or giving personal care", should have triggered further exploration with Guardian 1, stepfather, and Beta. Disclosures by cousin 2 that Guardian 1 was mentally abusing

her and shouting at her all the time, and that he had pulled Beta's trousers down to smack her bottom, did lead to CSC involvement but Beta was not spoken to regarding cousin 2's claims. Beta reported that her behaviour did change, she stopped being talkative, became distant and was over dressed, but this was either not noticed or explored by practitioners.

11.6.9 Research on identifying and responding to disclosures of child sexual abuse[18] has identified a number of key messages for practitioners:

- Children's disclosures of sexual abuse vary in the mode of communication, intent, spontaneity, and amount of detail that is included. Disclosure is best understood as a process which is influenced by relationships and interactions with others and may extend over a considerable period.
- Rates of verbal disclosure are low at the time that abuse occurs in childhood. However, children say they are trying to disclose their abuse when they show signs or act in ways that they hope adults will notice and react to. This is particularly important for disabled children.
- Professionals need to keep in mind that any child could be attempting to disclose, but certain children may face additional barriers to disclosure because of their disability, gender, ethnicity and/or sexual orientation.
- The act of disclosing sexual abuse can heighten shame and guilt. Others' negative reactions to disclosures may compound these impacts. This should not stop professionals from providing opportunities to children to disclose, but it is essential that children and their families receive appropriate support following disclosure.
- A range of complex and interacting individual, relational and social barriers may prevent children from disclosing abuse to professionals or anyone else. Teachers are the professionals to whom children will most commonly disclose, but the disclosure process can be helped or hindered by the way in which any professional engages with a child about whom concerns exist.
- Children want to be noticed by friendly, approachable, and caring professionals, with whom they have built a trusted relationship. They want to be asked how they are doing and what is going on, so they have an opportunity to have an open dialogue.
- Confidentiality is important to children but can be difficult to balance with professionals' safeguarding responsibilities. Professionals may experience a tension around this in their relationship with the child. If maintaining confidentiality after a disclosure may not be possible, it is important to be open, honest, and transparent with the child.

11.6.10 It is imperative that children are provided the opportunity to speak out and are asked the right questions. Nationally, in training, practitioners have been discouraged from asking children leading questions so as not to impede criminal investigations, this message seems to have inadvertently impacted on practitioner's confidence to ask any questions. Without some questions being asked, it is unlikely children will speak out. What helps children tell?[19] addresses the question of what helps children disclose experiences of child sexual abuse. It established two key dynamics that help children with six associated facilitating factors:

- The Need to tell,

[18] Centre of Expertise on Child Sexual Abuse (2019) Identifying and Responding to Disclosures of Child Sexual Abuse

[19] What Helps Children Tell? A Qualitative Meta-Analysis of Child Sexual Abuse Disclosure (icmec.org)

  - Realising it is not normal
  - Inability to cope with emotional distress
  - Wanting something to be done about it
- The Opportunity to tell.
  - Access to someone you can trust
  - Expecting to be believed
  - Being asked

11.6.11 When decisions were being made to take no further action or to make onward referrals to Early Help for support, opportunities for Beta to tell were missed as this meant no SW was directed to visit and speak with the children to ascertain their wishes. This is especially significant at the point stepfather was being released from prison. CSC were aware stepfather had been having contact with the children over the telephone; the children's wishes and feelings regarding this contact could have been explored and should have had a direct influence on what was to happen next. It is possible stepfather was able to groom Beta from prison, what is not known is whether this prompted any change in Beta's behaviour that might have been detectable by professionals.

11.6.12 Beta is extremely articulate and bright, who given the right circumstances and being asked the right questions may have felt able to disclose earlier. Practitioners need to be mindful that they are not waiting for a verbal disclosure but are ensuring all opportunities to tell are being provided.

11.6.13 Beta in discussion with the reviewer talked about social workers "coming in like seagulls and creeping out like crabs". Beta indicated they would swoop in with an increase in visits and activity and then their involvement just petered out without Beta understanding why. No one ever asked her whether her situation had improved or whether she felt it was the right time to cease involvement.

11.6.14 Beta felt she had trusted too much before she lost trust. Beta described sharing information with practitioners and then discovering other practitioners had knowledge of what had been discussed. This left her questioning how they had obtained the information. Beta was not asked for permission to share her information or informed how her information was going to be used or shared. This had the impact of reducing her trust in practitioners and she learned over time not to tell anyone anything.

11.6.15 Beta described a marked change in her responsibilities after Guardian 2 died. Beta described a household were she and cousin 2 were responsible for cooking, cleaning, housework as well as caring for sibling 2, whilst Guardian 1 and her male cousin fetched and mended things. Beta described being scared she would be shouted at or told off if she did not do what was expected. Beta and cousin 2 would discuss Guardian 1's treatment of them comparing it to slavery and calling it abuse amongst themselves. On one occasion Beta and cousin 2 packed their bags and ran away but they did not have the confidence to stay away so returned home without anyone knowing. Beta experienced emotional abuse from Guardian 1. On one occasion Beta recalled Guardian 1 threatening to telephone the SW and ask her to come and take Beta away. Beta recalls wishing the SW would come soon. Beta was treated like a stranger all weekend and fed only leftovers from the family meals. On another occasion, as a punishment, Beta was made to stand at a door for up to 4 hours or would have her electronic devices removed; the longest they were confiscated for was 8 months. Beta indicated she had kept her distress hidden, crying in secret.

11.6.16 Beta indicated that she felt if a practitioner started to see signs that were suggestive of abuse they should take the child out of the situation, ask questions and be clear that they were there to help the child over the adult.

11.6.17 Beta indicated she felt she was being treated differently in the house. Guardian 1 accused Beta of hurting sibling 2 and told her he had installed cameras to keep an eye on her; Beta indicated she had no privacy.

11.6.18 Beta informed the reviewer that she had experienced bullying in school and indicated she felt it took ages for any actions to be taken and that reports of bullying were not being taken seriously.

11.6.19 Beta indicated her experiences had left her with anxiety.

11.6.20 In discussions with practitioners, it was clear that messages given to practitioners within training to “not ask leading questions” are stopping practitioners from responding to young people when they might be ready to disclose. A clear message was given by police colleagues that leading/probing questions can be asked as long as they can be rationalised and are well documented. There needs to be a human response to the child.

Learning point 10: The children’s voices were not being heard for a number of reasons. Either, practitioners were not acting on small but potentially significant pieces of information because of messages received within training not to ask leading or probing questions, there were limited opportunities for contact with health practitioners, or because of decisions to take no further action following referrals and notifications. There is strength in the opportunities the schools provided Beta to talk, however concentration needs to be on the quality of the contact. Considering Beta’s information, in the context of what helps children tell, it can be concluded that decisions to take no further action reduced the number of opportunities Beta had to tell. The impact of information sharing without explaining to Beta that was going to happen, reduced trust. Lack of decisive action following reports of bullying reduced Beta’s sense that she was being believed. Apart from sibling 2, all the children were of an age where they could have contributed to practitioner’s decision making. A lack of wider thinking, and full exploration, of the referred issues with the children has meant opportunities to further understand their lived experiences have been missed.

11.7 Explore how practitioners formed their view of Guardian 1 and his ability to keep the children safe.

11.7.1 Practitioners’ views on Guardian 1 and his ability to keep the children safe are largely based on how he represented himself to them, rather than through formal assessment.

11.7.2 Guardian 1 was viewed as caring who in the face of adversity was willingly taking on board the care of 4 children. These are qualities that were seen in a positive light by practitioners. Guardian 1 also acknowledged that at times he needed support and would seek this support out himself. This was again seen as a positive. In addition, Guardian 1 made timely communication with CSC and the children’s school following the death of his wife. Guardian 1’s communication with school was reported to be generally good; this was particularly evident during Covid-19 lockdown when there was lots of communication and acceptance of home visits.

11.7.3 Because Guardian 1 was seen as someone who was doing his best for the children, wider thinking regarding motivation was barely considered. When issues arose,

these were always seen in context of a Guardian 1 trying to keep the family safe and together. Guardian 1 gave the impression of being open to service involvement and compliant, he was seen as someone who had the best interests of the children at heart. There was no evidence that Guardian 1 couldn't keep the children safe whilst stepfather was in prison however, practitioners did not know that stepfather had been having telephone contact with the children contrary to the conditions placed on him as part of his sentence.

11.7.4 When school were informed by Guardian 1 that sibling 2 was going to have contact with stepfather, they made an assumption that there would be some oversight, and as they had no safeguarding concerns, they did not see it as necessary to refer to CSC. There was insufficient consideration as to whether Guardian 1 would be capable of keeping the children safe once stepfather was released from prison. The belief that Guardian 1 could supervise the contact led to a lack of assessment by CSC at that time. Consequently, this prevented a clear plan of action being developed; the lack of plan was compounded by Covid-19 which affected practitioners' ability to have direct contact with the children. Covid-19 and the National lockdown, reduced practitioners contact with the children, the children's opportunities to disclose, and practitioners' abilities to monitor the situation.

11.7.5 Guardian 1 was well known to Primary Care due to living with poorly controlled type 2 diabetes and experiencing anxiety and depression with an associated stammer. Guardian 1 also had 2 x historic convictions, one for Actual Bodily Harm (ABH) in the 1990's and the other for theft in the 1980's. Whilst Guardian 1's past offending behaviour would likely have been considered in the early days and triangulated with the SGO, over time this was less likely to have been considered. There is no evidence that practitioners were considering that Guardian 1's past offending behaviour might remain relevant to the safety of the children. Whilst past offending does give historical context, in the absence of any offending for many years, it becomes understandable that it was not seen as particularly relevant. However, a letter from stepfather to Guardian 1 asking for £30k and for Guardian 1 to 'keep quiet', that was intercepted by prison staff and notified to the police provided an opportunity for greater professional curiosity as to whether there were any indicators that Guardian 1 might be involved in criminal activity. This letter has now been lost.

11.7.6 On one occasion, during a home visit, the family HV had confronted Guardian 1 who then displayed aggressive behaviour. Guardian 1 was struggling with media attention and both he and Guardian 2 felt under scrutiny; sibling 2 was present. The HV noted her concern regarding this. Sibling 2 and Guardian 2 were asked some simple questions regarding Guardian 1's behaviours, both supported Guardian 1. Guardian 1 did not want the HV in the house and made a complaint. Guardian 1 was given a change of health visitor, and when the new HV took over there were no further problems or concerns with Guardian 1.

11.7.7 When Police were attending incidents, as in all cases, stepfather's PPRC status would not show as a warning marker on the Police National Computer (PNC). Stepfather's previous convictions would have shown and if he had been a registered sex offender this would have been evident. Risk to children flags are shown on NICHE (police records management system) and ViSOR (Violent and Sexual Offenders Register).

11.7.8 There was a written agreement in place with Guardian 1, regarding supervised contact following stepfather's release from prison; however, it was not legally

binding. CSC did not explore the nature of stepfather and Guardian 1's relationship or speak directly to stepfather when making the decision regarding supervised contact.

11.7.9 There was no indication that the GP/ Nurse who completed Guardian 1's consultations considered him a risk to children. There was consideration of the need to liaise with CSC in order to establish support for him when he presented as not coping in February 2019. This may have been considered a normal response to bereavement; however, Guardian 1 did have physical as well as mental health conditions which would have been a challenge at the time alongside acute emotional stresses. Guardian 1 engaged well with the vaccination programme (influenza and Covid-19) and whilst these occasions presented opportunities to explore his wellbeing further, in reality Guardian 1 rarely engaged in health promotion and so there were limited opportunities for any practitioner to explore anything else with him during Covid-19.

11.7.10 There is no evidence of the GP being aware of stepfather's release from prison and visiting or staying at Guardian 1's address. It is unlikely there would be a connection between Guardian 1 and stepfather and the implications of stepfather staying at this address.

Learning point 11: It can be difficult for practitioners to remain objective when working with families over a prolonged period of time. Practitioners generally took at face value what Guardian 1 was telling them. Guardian 1 was viewed as a caring grandad doing his best for his grandchildren. Practitioners were not considering whether there might be issues of disguised compliance. A lack of assessment and SGO support, coupled with a lack of professional curiosity and wider thinking regarding motivation, led to a situation where these children's safety was compromised.

11.8 The decision making that led to PPRC not being included in the key lines of enquiry used in the previous Serious Case Review.

11.8.1 The reviewer learned that stepfather's PPRC status was discussed at the Child Death meeting. The Health Visitor had expressed concerns that stepfather was taking sibling 2 to clinic unaccompanied whilst classed as medium risk. The GP was not aware of stepfathers PPRC status. Overall, there was a lack of clarity regarding the risk stepfather posed. School was informed by the SW that stepfather was low risk and had permission to collect the children from school.

11.8.2 It was known that stepfather had connections with at least two associates both of whom had PPRC status. Whilst stepfather had committed a number of previous offences, these were of multiple types and the sexual offence conviction was historic. Stepfather was not seen as an active sexual predator.

11.8.3 At that time, whilst stepfather's offending history was an issue, it was thought not as problematic as the neglect.

11.8.4 There was a lot going on in the family with many neglect issues; these overshadowed everything else. Stepfather was driving whilst disqualified, there were issues of drift, neighbours were reporting concerns and there were concerns over grandparent's application for an SGO. There was also evidence of multiple domestic abuse incidents. Grandparents did not believe stepfather was guilty of the sexual offence and would strongly refute it. These issues, coupled with a focus on mother's ability to safeguard and parent, masked the PPRC concerns. What was

also overlooked was that mother was herself a victim of stepfather and others; she was a vulnerable adult. It was reported that she loved the children but lacked the availability to parent / safeguard them.

11.8.5 Had full information been known, the review team should have been clear that stepfather was deemed to be 'high risk'. However, it is clear that the review team also lacked understand regarding exactly what PPRC status meant in this case.

Learning point 12: Issues of neglect overshadowed the issue of stepfather's PPRC status. Whilst stepfather's PPRC status was discussed by the panel, lack of understanding regarding the level of risk stepfather posed, compounded by grandparents refuting that stepfather was guilty and a strong belief by Guardian 1 that once a prison term had been served there was nothing to answer for, distracted the review team and thus it was not fully considered as part of the SCR.

12. Examples of Good Practice:

- The Cafcass FCA acted within the expectations of the internal policy and the court by interviewing Guardian 1 and offering advice to the court regarding 'next steps'. Their advice that CSC needed to undertake further assessment of the family was appropriate and ensured that the proceedings could progress in a timely manner.
- Probation sought the views of CSC on advisability of contact and permission for contact was delayed until assurances were provided.
- Stepfather was accurately assessed by probation as posing a high risk of serious harm to children.
- School highlighted the family and offered support making regular home visits during the pandemic. Financial support was offered, and a key worker assigned to the family.
- School provided a good level of support to the children who all had excellent friendships with peers and good relationships with school staff.
- School completed a swift EHCP in respect of cousin 2 to ensure she would receive support from her secondary school.
- An attendance at the minor injuries' unit highlighted Guardian 1 as the child's guardian and that she was Looked After. This demonstrated a robust system and good information sharing.
- The GP records indicated Guardian 1 was a guardian of 4 children.
- The GP/Nurse identified the potential need for support and responded appropriately when Guardian 1 indicated he was struggling.
- Police attended on both occasions Guardian 1 expressed a wish to end his life and on one occasion spoke with the children allowing them an opportunity to share their concerns.
- The EHW encouraged Guardian 1 to engage and made visits to the home. Both Beta and cousin 2 were seen individually away from the home. The EHW and a SW from the F&F team completed a joint visit.
- Supervision offered to EHT worker and management decisions recorded.
- Each request for an SGO was responded to and assessed by CSC.
- After Guardian 2 died clarification was sought by frontline practitioners within CSC regarding whether the SGO for Beta and sibling 2 was in respect of both Guardian 1 and Guardian 2 and the concerns explored. Decisions

were signed off following advice at Assistant Director level.

- There were occasions that the FRT liaised with probation and sought clarity on parts of their information.

Appendix i – key to acronyms/ abbreviations

ABE	Achieving Best Evidence
CAFCASS	Children and Family Court Advisory Service
CAO	Child Arrangement Order
CCG	Clinical Commissioning Group (as of 1st July 2022 Integrated Care Systems (ICSs) became legally established through the Health and Care Act 2022 and CCG's were closed down.
CIN	Child in Need
CP	Child Protection
CSC	Children's Social Care
CSPR	Child Safeguarding Practice Review
CRC	Community Rehabilitation Company
EH	Early Help
EHT	Early Help Team
F&F	Family and Friends
FCP	Full Connected Persons
FRT	First Response Team
FRW	First Response Worker
GP	General Practitioner
HV	Health Visitor
KLOE	Key Lines of Enquiry
LAC	Looked After Children
LST	Local Support Team
MPFT	Midlands Partnership Foundation Trust
PNC	Police National Computer
PPRC	Person Posing a Risk to Children
PTSD	Post-Traumatic Stress Disorder
SCR	Serious Case Review
SGO	Special Guardianship Order
SSCB	Staffordshire Safeguarding Children Board
SW	Social Worker
ToR	Terms of Reference
UTI	Urinary Tract Infection