Working together to keep children safe

Staffordshire Safeguarding Children Board

Local Child Safeguarding Practice Review (LSCPR)

Final Executive Summary

Child I

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1. Introduction to the Review and Methodology

1.1. This Local Child Safeguarding Practice Review was commissioned by the Staffordshire Safeguarding Children Board in response to a report of sexual abuse and following Rapid Review for National Child Safeguarding Practice Review Panel submission.

1.2. On the 21st of June 2022, Children's Social Care received a section 47 referral in respect of the subject of this review, (hereafter known as Child I) aged 2 years. Staffordshire police had been contacted by another police force following an arrest in their area regarding a suspect uploading indecent images of children. During interview the suspect had disclosed that he had been communicating via social media with one of Child I's maternal uncles (hereafter known as Maternal Uncle 2) and Maternal Uncle 2 had sent the suspect a video showing intra-familial sexual abuse with Child I.

1.3. Since this time, another family member has also alleged that the male has sexually abused her, and another has alleged sexual abuse by Child I's maternal grandfather. Police are investigating these allegations.

1.4. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with a legal background, who gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews and both children's and adults safeguarding reviews, as well as domestic homicide reviews.

1.5. Allison does not have any links to Staffordshire Safeguarding Children Board or any of its partner agencies.

1.6. A multi-agency review panel[1] met on the 8th of December 2022 and considered the scope of the review. The panel decided that the review should focus upon the period from the 9th of October 2019, (the date when mum booked the pregnancy at 26+2 weeks gestation), until the 21st of June 2022, (when Children's Social Care received the aforementioned section 47 referral).

1.7. The panel agreed the Terms of Reference[2] and additional information was requested from the agencies involved (by means of agency reports) to aid the review process.

1.8. The panel met on two further occasions to discuss the case and learning and to monitor the progress of the review. In addition, the review incorporated two practitioner learning events attended by professionals from the key agencies[3] who had worked with Child I and wider family members. Contribution from all the professionals generated positive discussion around both good practice and areas of practice that could be developed and improved; this has formed the basis of this report.

1.9. It was agreed by panel members that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Children's Safeguarding Practice

[1] The panel consisted of representatives from Staffordshire Safeguarding Children Board, Staffordshire Police, University Hospitals of Derby and Burton NHS Foundation Trust, Staffordshire and Stoke-on-Trent Integrated Care Board, Children's Social Services, Midland Partnership Foundation Trust, Three Schools, and the Independent Reviewing Officer.
[2] Refer to Appendix 1
[3] Children's Social Care, Three Schools, School Nurses, Police, Community Midwifery, Health visitors, Child Protection Chair, and Staffordshire Safeguarding Children Board.

Review process will drive Staffordshire Safeguarding Children Board, and its partner agencies, to develop an action plan that will respond directly to the identified learning.

1.10. In line with the expectations for the final report panel members had an opportunity to review draft versions and to discuss and agree the learning prior to presentation, and ratification at the Staffordshire Safeguarding Children Board.

2. Family Engagement

2.1. Family engagement is an important part of the review process. Discussion with family members about the support offered is hugely beneficial to identifying both good practice, and practice which can be improved upon.

2.2. Whilst attempts have been made both at the beginning, and again at the end of this process to engage family members, they have declined to contribute to this review.

2.3. The perpetrator of Child I's abuse was invited to contribute to the review learning in the hope of gaining a greater understanding of abusers and preventative work. He declined to contribute. His Prison Offender Manager advised that he has verbalised strong remorse for his behaviour and is working to understand why he did what he did and reduce the risk of him repeating any such behaviour.

3. Parallel Processes

3.1. Following Staffordshire Police Service commencing a criminal investigation, Child I's abuser pleaded guilty to one charge of sexual assault and eight charges relating to making and distributing indecent images. He was sentenced to 68 months imprisonment and made subject to a Sexual Harm Prevention Order

3.2. Care Proceedings are ongoing for Child I at the point of publication.

4. Background Information

Child I and her Family

4.1. Child I was born in 2020. Mum and Dad[4] were both 22 years of age at the time.

4.2. Mum has four older siblings and seven younger siblings. Mum's family are known to have previously lived in Staffordshire, but then moved to the South West of England in 2007, moved again in 2010, until 2017 when they relocated to West Yorkshire.

4.3. It is known that children of Mum's mother (Child I's maternal grandmother, hereafter known as MGM), and Mum's father (hereafter known as MGF) were subject to child protection plans in both the South West and West Yorkshire. When the family lived in the South West, Children's Social Care had planned to issue care

[4] Child I's parents as referred to as Mum and Dad throughout the report.

proceedings, but when the local authority attempted to visit, on the 1st of January 2017, they found the family gone. It is not clear whether Children's Social Care ever learned of the family's subsequent destination being West Yorkshire, but this review would question whether this is an issue of national interest in terms of movement across boundaries and national alerting systems.

4.4. The family moved back to Staffordshire in 2018 and have lived at the same address since. Initially in 2018/2019 Child I's school age aunts and uncles[5] were educated at home. This is despite them living with a plethora of needs which include educational needs, learning difficulties, speech and language difficulties and mental health issues.

4.5. There is a documented history of Mum's family members not engaging well with support services. Healthcare appointments were often unattended and GP registration was not consistent - although family members did register with GP Practices in the area, and by May 2020 all family members, with the exception of the perpetrator of Child I's abuse, were registered.

4.6. There is a history of intra-familial and inter-generational sexual abuse within the family.

4.7. Child I's Dad was subject to Care Orders between the ages of 13 and 18 and reported a history of mental health issues (including depression, low mood, anxiety, panic attacks and self-harm) to health professionals. He is also known to have a history of drug abuse as a young person.

4.8. His family do not reside in the same locality, but Dad has disclosed that his mother (Child I's paternal grandmother hereafter referred to PGM) lives with schizophrenia and that his stepfather abused him. It is also known that PGM accused Dad of inappropriate sexual behaviour with his younger sister when he was a teenager. Dad denies these allegations.

5. What Was Life Like For Child I?

5.1. It is very difficult to gain a true understanding of Child I's lived experience. Documentation provided to this review evidence that professionals witnessed Child I to have a good bond with parents and to present as happy, but contact between professionals and Child I, Mum and Dad was sporadic owing to both Covid restrictions and parents not always presenting Child I for appointments.

5.2. In addition, Child I was of a pre-verbal age throughout the review scoping period. To understand how we can hear the voice of a preverbal child and learn of their lived experience, this report will reflect upon what is known about how a preverbal young child 'remembers' their experiences and absorbs their environment. Dr Amber Elliott wrote[6], *Babies have neither the ability to talk, nor even to think in an organised enough way to think using words. Their memories are stored in a non-verbal, procedural way… sensory memories are completely different from verbal memories and stored in an entirely different part of the brain. However, they are as powerful, if not more powerful, than verbal memories*

[5] Maternal Uncle 2 was an adult when the family returned to Staffordshire and was therefore not part of any child assessments or child protection planning.

[6] Trauma Memory - The Child Psychology Service

5.3. This suggests that even though preverbal children are unable to communicate their experiences verbally they still hold the information. And it highlights the importance of infant observation in order to gain a child's views. In the absence of a physical voice, practitioners must describe a child's physical appearance and observe their interactions. How does the child react to a loud noise? Is the child comfortable around strangers? Does he or she look to mum for reassurance, or dad, or a sibling? Does he or she smile, present as happy? Does he or she cry? Is he or she impassive? Such observations will give some insight into the voice of the child. To accompany this voice with the lived experience, practitioners must then establish what a day in that child's life is like.

5.4. Child I's assessment could have been improved with more description of her behaviours, presentation, and daily living experience within her 'views and comments' section of the assessment. Instead, the assessment notes that *due to her age and stage of development it has not been possible to ascertain the views and comments.*

5.5. This review has attempted to reflect upon what life was like for Child I during the scoping period. Some of this reflection is contained within the body of the report but it will begin with this overview:

As an unborn child, Child I was dependent upon her mummy attending ante-natal appointments to ensure that she was provided with regular care and her development in the womb was monitored. In the event of this not happening, Child I was reliant upon professional identification of missed appointments and professionals encouraging mummy to attend.

Child I was born in Good Hope Hospital and discharged, with her mummy, the following day to her maternal grandfather and grandmother's address. Her mummy told the midwives that they were going to stay there for two weeks whilst they were waiting for a couple's placement at a mother and baby unit.

Child I and her mummy and daddy ended up staying at her grandparents' house for around eight months. Also, at the address were three of Child I's aunts and two of her uncles. One of the uncles was Maternal Uncle 2.

In total, thirteen people lived in Child I's grandparents' home (a four bedroomed property), which is why, Child I's mummy and daddy slept in bunk beds, and Child I slept in a Moses basket at their side. Maternal Uncle 2 and another uncle were in a bed in the same room.

As Child I developed, she was given lots of attention from everyone within the household and was 'smiley'. She developed a good bond with both of her parents.

Both Child I's mummy and daddy lived with mental health issues. Daddy had prescribed medication to help him, but he did not always take it. Daddy told his doctor that his anxiety affected him daily; sometimes he even struggled to go to the shops. Mummy told healthcare professionals that she was able to control her anxiety.

When Child I was around six/seven weeks old, she became unwell. Child I demonstrated that she felt uncomfortable and unwell by crying. Her parents took her to hospital and healthcare professionals diagnosed colic and over feeding.

When Child I was nine weeks old, she and the rest of the United Kingdom became subject to Covid lockdown. All of the family were now mostly confined to the house.

Child I met a new person soon after; a Social worker who came to look at her and speak with her parents. As a result of the conversations, Child I was made subject to Early Help provision which meant that a lady helped Child I's mummy and daddy to get their own house ready for them to move in to.

Child I was used to living in a large family. However, in September 2020, when she was around eight months old, she and her parents moved into their own home. In this home, Child I had her own bedroom. It was decorated really nicely. There was another bedroom in the property where her mummy and daddy slept.

Soon after, Maternal Uncle 2 came to live with them. He slept on the sofa in the lounge and sometimes daddy would sleep in there too.

Though Child I was developing, she was still fully reliant upon her parents to provide her with a warm, safe home and ensure that all her health and basic needs were met. Mummy and daddy ensured that food was always available for Child I, and that she had plenty of toys to keep her busy, but she was sometimes not taken to appointments or made available for the health visitor to check on her.

Child I still saw her extended family a lot as she would go daily with her mummy. It is not known if Child I ever got left alone at grandparent's address, but it is clear that she must have sometimes been alone with Maternal Uncle 2. Child I was being sexually abused by Maternal Uncle 2 but because Child I was so young, she was unable to tell anyone what was happening, or that Maternal Uncle 2 was hurting her.

When Child I was around 18 months old, her mummy and daddy decided that they didn't want to be together anymore. Daddy still lived in the house with Child I and her mummy, but he became depressed and unhappy. In September, daddy reported to his doctor that he had a breakdown and had been cutting his stomach as this helped him to cope. Daddy said he was having suicidal thoughts.

Around the same time, Maternal Uncle 2 was taken away from Child I's home and a social worker and some Police Officers came to speak to her mummy and daddy. Child I was totally dependent upon her mummy and daddy not to leave her alone with Maternal Uncle 2. Though the police suspected that Maternal Uncle 2 had been distributing indecent images of Child I, only Child I knew how Maternal Uncle 2 had been hurting her. She was too young to verbally tell anyone. Child I's mummy and daddy didn't believe the police about the indecent images.

At first Maternal Uncle 2 moved out of Child I's address but soon Child I and her mummy moved back to her grandma and grandad's address. Daddy stayed at the old address and Maternal Uncle 2 moved back in with him. Around this time, Child I's family were upset because Child I's grandma was told that she was very unwell. There were arguments in the household, particularly between Child I's grandad and one of Child I's aunts. Child I was overdue her one-year review with her Health visitor but because mummy had 'a lot going

on' she wasn't taken or seen until she was followed up by the health visitor in a targeted review at a later stage.

In time Child I and her mummy moved back to their old house with daddy, and Maternal Uncle 2 moved out. Happily, mummy found out that she was having another baby. But there were arguments at this house too and one day, Child I's mummy got angry and pushed daddy and smashed a mirror. Child I and her mummy went to stay with grandma and grandad again for a few days.

A month later, Maternal Uncle 2 was taken away by the police. Child I didn't know this or understand why - but the family were visited by more Police Officers and mummy and daddy got very upset.

Only Child I knows whether Maternal Uncle 2 was able to hurt Child I again before his final arrest.

6. Thematic Analysis

To enable the review to meet the Terms of Reference, panel members and professionals at the learning events discussed the professional practice afforded to Child I and her family. This section of the report looks at the thematic issues that the discussions highlighted.

Professional Response to Inter-Generational and Intra-Familial Sexual Abuse

6.1. A history of sexual abuse and sexualised behaviours within Child I's wider family became known to Staffordshire Children's Social Care in April 2020, when it was shared by other local authorities. The information shared included:

- MGM had been sexually abused by those who adopted her as a child,
- The third child born to MGM and MGF was a High-Risk Person Posing a Risk to Children, and
- There had been multiple disclosures of sexualised behaviours occurring between many of the aunts and uncles.

6.2. In addition, during Child Social Work Assessments undertaken in April 2020, it became known to Children's Social Care that PGM had historically reported:

- Dad displaying sexual behaviour against his much younger sister, and
- Dad having witnessed her being raped by his father on multiple occasions as a child.

6.3. Intra-familial[7] patterns of sexual abuse such as these are complex. However, it is important that professionals understand them because a poor understanding can potentially lead to increased risks to children. Particularly because this type of abuse can become a cycle in which people who are victims abuse others - blurring the line between victim and abuser. Professionals also needed to bear in mind that this type of harm is often hidden from view and consequently the detail and frequency of the abuse within the wider family would remain unconfirmed. For many reasons[8], much child sexual abuse within a family, is not spoken of but it is believed that such abuse may take place for many years and is rarely a one-off incident.

[7] Intra-familial sexual abuse refers to sexual abuse that occurs within a family environment.

[8] Statistics briefing: child sexual abuse (nspcc.org.uk)

6.4. This needed to be understood when the sexual behaviours became known to professionals in Children's Social Care, and any potential risk needed to be shared with the professionals who were working to support Child I and her wider family.

6.5. The information received about the sexual behaviours within the family should have raised professional curiosity around the levels of supervision within the wider families, the relationship education that the wider family (including Mum and Dad) had received, and underlying factors such as what Child I's parents and wider family members may have been exposed to. The information warranted further enquiry, including, had the sexual behaviours been 'consented' to? What work had already been undertaken with the individuals affected? Instead, this review has been informed that professionals in Children's Social Care formed a presumption that the sexual behaviours disclosed, had been addressed by the professionals in the previous localities where the family had lived.

6.6. It is important not to make such assumptions because without any detailed information of the work (including its quality, and its effectiveness) that had been undertaken with family members being known and understood by Children's Social Care professionals, it was not possible to know what the current concerns were and who may be affected.

6.7. Some professionals have informed this review that in addition to presuming that the behaviour had been addressed, they were reluctant to discuss the behaviours with the children for fear of re-traumatising them. Relevant support and training must be offered to professionals regarding how to have these hard conversations, as whilst children who have experienced harmful sexual behaviours will all respond differently - many will be traumatised. Significant adults around them can help them recover – those adults often being professionals.

6.8. The professionals in Children's Social Care who have engaged with this review have reflected upon the assumption that the sexual behaviours had been addressed and have recognised that no work was ever clarified. They now appreciate the need to seek and share such significant information.

Question 1:
How can the Staffordshire Safeguarding Children Board and its partner agencies strengthen practice around understanding the significance of family history, (particularly where there is a history of harmful sexual behaviour/abuse) and the importance of seeking information to understand any work undertaken to address its effects?

6.9. Service response to sexual abuse was discussed in the learning events, and professionals' frustration regarding a shortage of specialist sexual abuse workers was clear. Social workers explained how they are trained in communicating with children but have no specialised training regarding talking to children about sexualised behaviours, and other professionals agreed that they did not feel qualified to deliver such specialist services. Professionals then deliberated how there were no longer NSPCC[9] services in the area and no resources to fund other work.

[9] National Society for Prevention of Cruelty to Children.

6.10. Nonetheless, panel members noted how in addition to the NSPCC other local provisions are available:

- The Sexual Abuse Rape Advice Centre[10] offers confidential support to individuals at risk of, or who have experienced sexual violence or rape. As part of the charity's mission, they work in educational settings and have four dedicated Young Person's Counsellors who work to bring about awareness to young people of the support available to those who have experienced sexual abuse and educate to reduce the likelihood of offenders in the future.
- The Sexual Assault Referral Centre[11] offers medical, practical, and emotional support to anyone who has been sexually assaulted or raped. An individual can access a range of services that are free and confidential and there is no obligation to have involved the police.
- Women's Aid[12] provide practical help, advice and support and have Children's Independent Sexual Violence Advisors who can be accessed even when an incident has not been reported to the police.
- Savanna[13] provide free counselling and support services for anyone from the age of 4 who has been affected by sexual violence and abuse.

6.11. There is also a UK-wide charity dedicated solely to preventing child sexual abuse; 'Stop It Now! UK and Ireland'. The charity is run by The Lucy Faithfull Foundation and is there for anyone with concerns about child sexual abuse and its prevention. Upon learning of the inappropriate sibling behaviours, school and education professionals could have sought advice from 'Stop It Now!' regarding how to respond and could have encouraged the family to do so also. 'Stop It Now!' offers free one-hour call-backs with specialist school practitioners and up to three hours' free consultancy for schools who need extra support including detailed safety planning work, twilight staff training sessions and parent/student workshops. There are also helpful guides available on their website to help education professionals understand sexual behaviour in children and to safety plan.

6.12. In addition, The Lucy Faithfull Foundation provides a range of services for organisations, professionals, and the public, including risk assessment and intervention; specialist consultancy; expert training and public education. The Foundation offers much professional training including 'Working with families affected by sibling sexual abuse: a roadmap for safeguarding'. However, these services cost and as mentioned, funding is a problem which needs to be prioritised for consideration.

6.13. This review has also been informed of a new multi-agency strategy[14] 'Preventing and Responding to Problematic and Harmful Sexual Behaviour' which has been launched in March 2023. The strategy sets out the commitment by Stoke-on-Trent and Staffordshire to address the issue of problematic and harmful sexual behaviour and aims to help professionals understand problematic and harmful sexual behaviours and know how and where to seek support for children.

[10] SARAC: Sexual & Domestic Abuse & Rape Advice Centre | The Survivors Trust
[11] Grange Park - Supporting the victims of Rape or Serious Sexual Assault
[12] Sexual Violence and Abuse - Staffordshire Women's Aid (staffordshirewomensaid.org)
[13] Savana
[14] Preventing-and-Responding-to-Problematic-and-Harmful-Sexual-Behaviour-Strategy-2022.pdf (staffordshire-pfcc.gov.uk)

Question 2:

How can Staffordshire Safeguarding Children Board seek assurance that professionals from all agencies understand what specialist sexual abuse support services are available and how to access them?

6.14. Regardless of specialised training and support services, fundamental practice around intra-familial abuse and inter-generational abuse must include a good application of information sharing, thorough assessment of safeguarding concerns, and professional curiosity. This will assist professionals to not only identify individuals at risk of abuse but will also assist identification of potential offenders. Which is important because, as previously mentioned, sexual abuse can become a cycle in which people who are victims abuse others. However, it is crucial to reiterate that this is not to say that all victims of abuse will go on to abuse others - research tells us that there is no 'typical' abuser - but the potential cycle does highlight the clear need for a coordinated service response to engage with children and young people as perpetrators as well as victims.

6.15. Individuals with Sexually Problematic Behaviours are often persecuted by the public. Professionals must put any personal opinion they may have to one side and accept the challenge of encouraging individuals with such behaviours to seek support to help them to manage their behaviours. This will potentially subsequently reduce their risk of offending.

6.16. Maternal Uncle 2 was very much a 'hidden' family member and professionals did not know enough about him to identify any potential risk. He wasn't registered with any GP Practice and there was no known care or support needs which would induce any professional organisations to offer him their services.

6.17. Some professionals were aware of the alleged sexual abuse by Dad against his sibling. When this was discussed with him, Dad denied the behaviour, offered an explanation, and became upset. Only Dad knows whether there is any truth in the allegation.

6.18. Admission of sexual abuse within the circumstances Dad found himself in was never likely. Besides the risk of prosecution, and condemnation of others, accused perpetrators of abuse are potentially battling guilt, and/or shame. In recognition of this, support services who will work constructively with individuals experiencing sexually problematic thoughts and/or behaviours, need to be made more widely known.

6.19. The Corbett Centre is an initiative of the Safer Living Foundation and is the first of its kind in the United Kingdom. It aims to support people convicted of a sexual offence to safely reintegrate into the community and reduce the number of victims of sexual abuse and harm. However, it also aims to support individuals with problematic sexual thinking. Individuals can be referred by many agencies but can also self-refer. Sadly, the centre is not able to offer its services outside of Nottinghamshire, Derbyshire, or Lincolnshire but conversation with some of its 'service users' evidence that individuals with problematic sexual behaviours and/or thinking often want help to manage their thoughts and need to know that help does exist.

6.20. In the absence of anything like the Corbett Centre being available in the local area, individuals with problematic sexual behaviour/thinking in the Staffordshire area must be encouraged to seek support from

the Lucy Faithfull Foundation. The Lucy Faithfull Foundation provides information and support for people troubled by their sexual thoughts about children and young people. Their website[15] aims to *help people to cope with unwanted feelings and urges and offers guidance about how to manage problematic behaviour,* and their helpline is free, anonymous, and completely confidential.

6.21. Presently, the Lucy Faithfull Foundation is too often only signpost after an individual has offended and been arrested. Better practice would see this change with individuals being helped to understand that support is available prior to them committing an offence and abusing a child. Given that as mentioned, it is unlikely that a potential offender will volunteer his or her problematic sexual behaviour/thinking, signposting to support must be made visible. The Lucy Faithfull Foundation has assured this review that they are encouraging of their helpline and other services being widely shared and this can be done using their posters, leaflets[16], and videos[17].

Question 3:
How can partner agencies assure Staffordshire Safeguarding Children Board that work is being undertaken to signpost individuals with Sexually Problematic Behaviours and/or thoughts to support such as The Lucy Faithfull Foundation?

6.22. As is evidenced by information that was shared regarding female members of Child I's family having behaved sexually inappropriately with family members, this signposting practice is not just relevant to the male population. Sex offenders are not just male - in 2022 the Lucy Faithfull Foundation had 78 females contact the helpline who were concerned about their own thoughts and behaviour towards children. 41 of the females had made contact regarding online behaviour. This is 2.6% of callers/chatters.

Professional Application of a Think Family Approach to Safeguarding Concerns

6.23. Mum registered at the medical practice and presented at midwifery pregnant with Child I (at 26+2 weeks gestation). Dad presented at midwifery with Mum but did not register with the practice. The community midwife knew nothing of either parent and consequently in this situation, the midwife was heavily dependent upon the willingness of parents to disclose key events and incidents from their past history.

6.24. Mum gave birth to Child I in Good Hope Hospital and her handheld midwifery notes would have been filed there following the birth. Consequently, this review has been unable to obtain full detailed midwifery information, but the chronology has informed that Mum disclosed a history of depression and historic cannabis use at the booking in appointment. Mum also explained that her pregnancy care had transferred from another area. This is likewise evidenced in the assessment undertaken in April 2020 during which Mum stated that *she found out she was pregnant at around 12 weeks and found out she was having a girl at 20 weeks.*

[15] Get support website for people worried about offline offending | The Lucy Faithfull Foundation

[16] Posters and leaflets can be found at https://www.stopitnow.org.uk/resources/.

[17] Videos can be found at https://www.youtube.com/@stopitnowukireland/videos,

6.25. This review has been informed that it is not usual practice across UK health services to request hospital antenatal records regarding a woman who has transferred in from another area unless they have a complex pregnancy. Consequently, there aren't any out of area records in the Staffordshire midwifery files. There is also often an issue with cross-border working because maternity electronic systems are not all the same and cannot communicate with one another. Further, UK health service records do not link up family members, children, siblings, and partners. At the relevant time, community midwives in Staffordshire were documenting in hand-held records. However, hand-held records from any area do not contain any detail of safeguarding concerns because, by their very nature, they are not able to be kept private from the public.

6.26. However, there is a system of good practice where when a woman moves from one area to another, and there are safeguarding concerns already identified, the community midwife or Named Midwife will contact the area to which the woman has moved and hand-over concerns to the team there. In this case this did not happen, and it is assumed that this is because there were no concerns. The only information known at the time of receiving care by University Hospitals of Derby and Burton NHS Foundation Trust (specifically, a history of mild depression and historic cannabis use), would not have been a cause for safeguarding concern or grounds to make a referral or enquiry to social care. Following on from this review, the University Hospitals of Derby and Burton NHS Foundation Trust will be in discussion with the National Head of Midwifery Network to press for a system of telephone discussion between community midwives or Named Midwives about any woman who is transferring care to another area - irrespective of whether there are known concerns or not. To follow this approach would ensure that midwifery are not working with women and their unborn baby on the basis of the apparent absence of evidence of concern.

6.27. Midwifery services continued to engage and support Mum during her pregnancy with the only source of information being parents. Had the other information been known, i.e., a history of neglect, transience, and abuse within Mum's family, it is possible that a pre-birth assessment would have been considered to assess whether Mum's and/or Dad's life experiences could impact upon their ability to parent. This is because it would have been clear that both parents had vulnerabilities which could impact upon their parenting and potentially pose a risk to Child I in the absence of appropriate support being offered or accepted. In summary the vulnerabilities included,

- both parent's poor experience of being parented,
- abuse/neglect in their childhoods,
- Dad's time spent in care (whilst it is important not to discriminate against care leavers it is important to acknowledge their history and to offer support to enable them to parent their own children),
- both parents' mental health issues and
- previous cannabis use.

A pre-birth assessment would have afforded an opportunity for professionals to work with Mum and Dad, gather information that had already been compiled by other areas, and assess any risk to unborn Child I or identify any support required.

6.28. It appears that the first professional working to support Child I and her parents who learned of any of the concerns re the wider family, was the social worker in April 2020. Whilst the cross border working regarding Child I's wider family could have been better (and as is evidenced by its recurrence in Safeguarding

Reviews for children and adults at risk alike, requires improvement) in the case of Child I, the issue is not just when the information was shared - but what was done with it upon receipt.

6.29. The Child Social Work Assessment undertaken in April 2020 recognised the risk from Mum's older brother who was a known risk to children, and it explored the sexual allegation historically made against Dad. But it did not holistically consider whether any other members of Child I's wider family may pose a risk to Child I given the inappropriate sexualised behaviours.

6.30. Following the assessments, Child I and her aunts and uncle[18] were deemed to require Child in Need plans, but Mum and Dad declined consent, agreeing to a referral to Early Help instead. There is no documented rationale for their refusal to work under Child in Need but in this case, it is understandable how both parents' histories of social workers could have potentially caused them to be wary of professionals becoming involved with Child I. It is plausible that they were fearful of social work involvement in Child I's life due to their own experiences. It must also be recognised that this could have made them less likely to be honest about their histories.

6.31. Upon professional's struggling to complete work with the aunts and uncle, an Initial Child Protection Conference convened. This was good practice, and this review has been informed that the reports provided to conference were comprehensive and included chronology of other local authority Children's Social Care involvement.

6.32. Child I was no longer living in the home address of MGF and MGM at this time, and consequently was not considered as being a subject of the conference. However, whilst she was referred to in the main body of the Child Social Work Assessment, given that Child I continued to attend the home address on a very regular basis, and was vulnerable due to her age, this review would respectfully ask whether she could have been afforded more consideration and included in the significant family members section of the report. This would have ensured that Child I was considered as a child impacted upon by the issues at conference.

6.33. This review has been informed that if Child I had been thought to be at risk from any of the issues regarding her grandparents' home, then the assessment which had been completed in relation to her needs in her own right, would have highlighted the further intervention required, such as an Initial Child Protection Conference. However, this would have resulted in two separate conferences, and it is unlikely that in the event of Child I no longer living at her grandparents' house, the full history of Child I's wider family would have been discussed.

6.34. Given the complexities of Child I's wider family, a 'Think Family' approach was required. It is recognised that professionals are not always aware of wider family members or of who visits a house frequently but in Child I's case, the information was there and known from April 2020.

6.35. At the aunts and uncle's protection conference, all the professionals in attendance became aware of:

- a family who had fled a previous authority when legal proceedings had commenced.
- a family who had then been subject to further child protection processes in another authority.

[18] Those aged under 18 years.

- disclosed sexualised behaviour amongst siblings.
- of older siblings (who were now adults) having engaged in sexualise behaviour, and
- of one of the older siblings posing a risk of sexual harm to children.

Best practice would have recognised that one of the siblings within this family was Mum who was now a mother herself. Though now an adult, consideration could have been had as to what her lived experience had been, what her understanding of the family dynamics was, whether she had been exposed to any of the sexualised behaviours and given that it was known that she had moved into the family home with a young baby and continued to frequent the address – what her understanding of risk was. At the very least, the conference could have actioned that the information be shared with professionals around Mum and Child I to allow them to learn more about the wider family and better assess any risk to Child I. And the potential risk wasn't just a sexual one, besides the harmful sexual behaviour, it was now known that individuals within Child I's wider family lived with mental health issues, self-harming tendencies, and suicidal ideations.

6.36. As said, the initial approach to doing this lay within a 'Think Family' agenda which would recognise and promote the importance of the 'Whole Family' approach. The approach would have seen more professional curiosity being applied in the conference regarding any risk to other individuals in the family who spent periods of time at the family home.

6.37. The conference chair has informed this review that the Think Family approach wasn't a specific model embedded into their practice at the time of this conference but has assured that it is now incorporated in Staffordshire. The conference assessment report now prompts the assessor to consider the wider family, and the opening stages of conference gathers information as to wider family members, roles, and relationships.

6.38. Agency reports provided to this review from other agencies within Staffordshire, evidence a varying degree of understanding and application of a 'Whole Family' approach.

Question 4:
How can partner agencies assure Staffordshire Safeguarding Children Board that professionals from all agencies are informed of a 'Whole Family' approach and supported to include it within their practice?

6.39. The next assessment undertaken with Child I was after Maternal Uncle 2 had been arrested for indecent images. On this occasion, Maternal Uncle 2 was released with bail conditions not to have any contact with anyone under the age of 18. The social worker undertaking Child I's assessment creditably visited Child I's home address, visited grandparent's home address, met with Maternal Uncle 2, completed checks with the health visitor (Child I was only open to health at this time), and liaised with police. The assessment closed with the recommendation that the information regarding Maternal Uncle 2 had been shared with Child I's parents and they understood his bail restrictions - although it was noted that neither believed the 'indecent images' allegation against Maternal Uncle 2. It also recorded that Child I and Mum had moved back into grandparents' address as Mum had concluded that was the safest option. And that Mum understood and was able to manage the risk.

6.40. The bail conditions changed in December 2021. Maternal Uncle 2 was not rearrested until June 2022. There is nothing to document that Mum and Dad were ever revisited in this time and/or that their ongoing

ability to safeguard and protect Child I, given the passage of time, was reassessed. This raises questions as to how robust agencies' responses are to circumstances in which police are unable to advance their investigation without further evidence, but when a crime has not been negated. Are enough safeguarding measures put in place, is the concern shared widely enough, or do agencies wait for a disclosure to be made, or charge/conviction achieved?

6.41. A Think Family approach at this time would have included consideration of any influence the wider family may have had upon Mum. Would all the family safeguard Child I or were they all in agreement that Maternal Uncle 2 was innocent. Is someone realistically able to safeguard if they don't truly believe the risk in the first place? And would Mum have been reassured of Maternal Uncle 2's innocence by other family members not believing the allegations – potentially resulting in less robust safeguarding?

6.42. When there are parallel criminal investigations and child protection concerns, professionals must remember that the police investigation will focus upon evidence and whether there is sufficient evidence to prove that a crime has been committed. A lack of evidence to progress to prosecution should not lessen the need for child protection, and social work does not need 'endorsement by the police' to act. Their work can be continued upon the balance of probability.

6.43. The experience of Child I points to the need to raise awareness around safeguarding responses when a person is accused of a crime, but no further police action can be taken, and for multi-agency partnership to further reflect upon improving this response. Better reflection is required of child protection procedure and less attention on the police process.

Question 5:
How can Staffordshire Safeguarding Children Board obtain assurance that partner agencies are safeguarding children from potential risks when an individual is suspected of a crime (which could put a child at risk of harm), but a charge/conviction has not been possible?

Safeguarding is Everyone's Business

6.44. In February 2021, following Child I's aunts and uncle's Child in Need plan being stepped down, a Special School Nurse opined reservations. The special school nurse discussed during safeguarding supervision how, upon reflection of the decision to close the Child in Need plan, she was registering concerns. She was advised to discuss her concerns with the social worker, but it was soon learned that the case was already closed. The special school nurse has informed this review that she was clear on escalation policies – that wasn't the issue. The issue was that her concern was based only upon a 'gut instinct'.

6.45. Whilst this particular practice concerns Child I's aunts and uncles, there is important transferable learning to be developed, as this 'gut instinct' or 'intuition' is clearly an influence that professionals are wary of accepting. However, it is one that occurs and improves as we gain experience - an experienced professional will subconsciously see patterns and will not take things at face value. This is a strength. After the Baby Peter case, Professor Munro stated: *"Our intuitive capacity is vast, swift, and largely unconscious. 'Reflective practice' is the time and effort spent to pull out one's intuitive reasoning so that it can be reviewed and communicated.*

6.46. Professionals may argue that they are required to justify all their decisions, nevertheless intuition/gut instinct should still not be ignored. The special school nurse was correct in discussing her concerns in supervision, but progress would see her having confidence in her intuition, trusting her own critical skills, and voicing her 'gut instinct' at the time – in the meeting. She bravely reflected how at the time she had questioned whether she was implying something that wasn't there. This doubt is understandable. Sitting in a room with other professionals, even the most experienced professional can sometimes question why no one else is raising an issue and/or feel under pressure to agree with the overriding opinion amongst the group. But intuition is an assessment tool that should be encouraged and applied.

6.47. The special school nurse remarked that the actions within the Child in Need plan had all been completed and said that this was a factor in her deeming her intuition to be non-justifiable. But raising her intuition in the meeting may have affected multi-agency professional curiosity of the plan and could have encouraged other professionals to critically reflect and open their minds. After all this was a complex family, and the more complex the circumstances, the more there is to reflect upon.

6.48. Professionals need to raise their individual concerns because as is clearly stated on the local Borough Council's website, Safeguarding is Everyone's Business. And this is dependent upon effective joint working between agencies and professionals that have different roles and expertise. Vulnerable children need coordinated help from professionals from all agencies and no professional should feel unable to voice their views and opinions. Everyone who works with children has a responsibility to share information and concerns that could impact on a child's welfare.

6.49. Upon hearing that the Child in Need case had already been closed, the special school nurse did not make a further referral as she expected the threshold to not have been met given that Children's Social Care had just closed the case and she had not identified any new significant information. Agencies involved in safeguarding may often disagree about a level of risk, and whether a referral to Children's Social Care is necessary - but this should not prevent any concerned professional from contacting Children's Social Care. Nor should it inhibit a professional from escalating concerns if they strongly disagree when Children's Social Care decides that no further assessment is required.

6.50. Linked to thresholds, there seemed to be a lack of recognition of the role organisations can play when a case falls below the statutory thresholds, by means of Early Help. In line with Safeguarding is Everyone's Business/Responsibility, Staffordshire's Early Help Guidance[19] for Practitioners reiterates that it is the responsibility of all practitioners *to identify emerging problems and potential unmet needs for individual children, young people, and families*. Any practitioner working with a family where children with additional needs are identified can use the Early Help Assessment model. Training is provided via the Staffordshire Safeguarding Children Board. It is understandable that some professionals may feel daunted by taking a leading role in the process of initiating Early Help, particularly if Children's Social Care has considered issues to have been resolved, hence the guidance supports professionals in this lead role.

6.51. Good safeguarding practice demands professional curiosity. And in line with Safeguarding is Everyone's Business, all professionals from all agencies must consistently employ professional curiosity within their work.

[19] Early-Help-Practitioners-Guidance.docx (live.com)

6.52. More curiosity could have been afforded Mum regarding her experiences within her family. When questions were asked during Child I's assessment in April 2020, Mum reported that her childhood was *positive* and that there had always *been a lot of love in her family home*. She said that she had *never wanted for anything* and that her family stuck *together to look after each other*. Mum had also physically demonstrated a trust in her own parents' parenting as she had moved into their property, when Child I was first born, reportedly for support. Yet in April 2020 when the assessment was being undertaken, it was known that concerns regarding Mum's parents' ability to care for their own children had become so great in previous areas that legal proceedings had been initiated. An absence of further curiosity into what Mum deemed to be *positive* contributed to professionals failing to gain an understanding of how Mum's history could potentially affect her current and future behaviours and parenting capacity.

6.53. Also, more curiosity could have been afforded when a visiting health visitor attended Child I at Mum's address and a male was observed to be smoking at an open window. Whilst his smoking around Child I was addressed, no further information was obtained other than he was a brother of Mum's. It is probable, given his guesstimated age that this was Maternal Uncle 2. This was a missed opportunity to learn of how much time Mum, Dad and Child I were still spending with Maternal Uncle 2 and how the bail conditions were being adhered to inside the home address. Did parents understand that even leaving Child I in a room alone with Maternal Uncle 2 constituted a breach of the agreement?

6.54. A common barrier to professional curiosity identified in many safeguarding reviews is professionals being over optimistic about a situation. With regards to Child I, were over optimistic assumptions made about Mum and Dad's ability to parent? Should Mum's repeatedly missed ante-natal appointments have been a potential indicator of a need for support with parenting? Was it later *hoped* that Mum and Dad were able to effectively safeguard Child I from Maternal Uncle 2. Both parents had admitted that they did not believe the allegations against Maternal Uncle 2. Better practice would have seen more professional curiosity around Mum's and Dad's understanding of the potential risks Maternal Uncle 2 could pose, and around parents' understanding of 'supervised'.

6.55. This review recognises how hard it can be for professionals to ask individuals potentially sensitive and intrusive questions, but they are a necessary part of safeguarding practice. Professionals must learn to be professionally curious and to view individuals through a wide lens that doesn't focus wholly upon the task concerned.

6.56. Professional curiosity is a concept which has been recognised as important within the area of safeguarding children for many years and, as highlighted in The Child Safeguarding Practice Review Panel Annual review, is a well-known theme identified in many Rapid Reviews and Safeguarding Practice Reviews. Consequently, it is already a current priority for Staffordshire Safeguarding Children Board and work has been started through action plans, the business plan and performance activity.

Question 6:
How can Staffordshire Safeguarding Children Board ensure that work to improve professional curiosity identifies barriers preventing curiosity and helps professionals to overcome them?

The effects of the Covid pandemic on the support offered to Child I and her family.

6.57. It is important that this review highlight that professionals supporting Child I and her wider family during the scoping period of this review, from March 2020 onwards were working under the everchanging backdrop of the regulations and restrictions introduced to control the Covid pandemic. And there is no doubt that during the whole of the Covid pandemic safeguarding practice became more complex. One of the main problems arising from the Covid pandemic was that it frequently left many agencies with reduced staffing levels as:

- Staff who had been exposed to the virus, had to self-isolate, and
- Staff who had been unfortunate enough to contract Covid-19 were off work.

6.58. Another major problem for professionals was that to reduce the risk of transmission of the coronavirus, the pandemic saw many professionals being prevented from visiting members of the community in their own homes and there was reduced access to people face-to-face. This review has heard how Covid restrictions had some impact on the usual delivery of some health services, and how Dad's appointments with the community mental health service were affected and Dad was consulted by telephone instead of face to face.

6.59. Also, there is evidence that Covid affected the administration of Child I's childhood immunisations as at least one member of her wider family was isolating due to Covid in her bubble and therefore she could not have immunisations at the required time.

6.60. It is commendable that Health visitors agreed on continued targeted contact with Child I face-to-face during the pandemic as a decision had been made by the 0-19 service that mandated contacts for babies and children would be sustained and home visits would still be offered where necessary.

6.61. Whilst Child I's aunts and uncles are not subject of this review, the professional support around them had a direct effect upon Child I who as a non-verbal child was reliant upon their disclosures of any safeguarding concerns within the family that could affect her. However, although all of the schools stayed open to Child I's aunts and uncles during the covid pandemic in recognition of their vulnerabilities, any absences were easily attributed to Covid and could go un-investigated.

6.62. It is clear that professionals working around Child I and her wider family during the Covid period worked hard to not allow the pandemic to reduce their support offer, but some effects were beyond their control. For example, the National Crime Agency has reported a 10% increase in online sexual abuse during lockdown. The Internet Watch Foundation reported its worst year on record for child sexual abuse online in 2021 as it confirmed 252,000 URLs containing images or videos of children being sexually abused, compared with 153,000 in the previous year.

6.63. And in 2022, when Maternal Uncle 2 was arrested, there were serious problems with the ability of the criminal justice system to deliver justice. In April 2022 the House of Commons Justice Committee noted that there was a backlog of 58,818 cases in the Crown Court. Whilst before the Covid-19 pandemic, there had been delays and backlogs in the criminal justice system, (said to be caused by influences such as a lack of

funding of the system, cuts to criminal legal aid, the closure of courts and a lack of availability of judges, legal professionals, and court staff), the Covid-19 pandemic and the social distancing rules contributed to further delays. The fact that jury trials could not be held during the pandemic led to an increase in the backlog in cases in the criminal courts. This review recognises that the delays in criminal court cases had effects on defendants, witnesses, and victims.

6. Good Practice

There is evidence of much good practice within several agencies who attempted to support Child I and her wider family, and it is equally important to develop learning from this good practice as it is from any shortcomings:

6.1. The GP Practice was tenacious in following up non attended appointments and making multiple attempted calls to ensure contact be had.

6.2. The health visitors followed up at home when it was known that Child I had not been brought to some of her review appointments. This would not be usual in terms of 0-19 universal service offer unless there is a professional concern or curiosity.

6.3. The social worker and team manager recognised the need for cross-border information and for a chronology to be completed that included all cross-border information.

6.4. The plan for aunts/uncle was escalated to Initial Child Protection Conference in recognition that the Child In Need plan was ineffective.

6.5. The assessment for Child I contained a good understanding of Dad's history and understanding of his childhood experiences.

6.6. Regular visits were completed during the period of Social Care involvement included face to face contact during the covid pandemic.

7. Developments

Since the scoping period of this review, agencies have already made some important amendments to practice. Some have been included in the body of this report. Other developments include:

7.1. One of the schools is in discussion with the Personal, Social, Health and Economic lead, and is developing some interventions, that will be delivered to all students regarding circles of trust and safety within the home and will be tailored towards keeping themselves safe emotionally. Also, as of September 2022, the school is consistently tracking and chasing safeguarding files for all new students. This is all documented. They will also start to review school history, so they know of student locations prior to starting with the school.

7.2. Another of the schools designated safeguarding lead has attended NSPCC supervision skill training to facilitate in depth consideration at all levels of cases in the school causing concern.

7.3. Partnership meetings take place approximately every 6 weeks with Staffordshire Children's Social Care and Named GP Safeguarding leads and are well attended. This provides opportunity to address issues regarding the reporting and attendance at conference and provides a quality improvement opportunity for the Integrated Care Board to raise standards across Primary Care. Staffordshire Children's Social Care provide monthly data of conference attendance and submitted reports, providing the Integrated Care Board with evidence-based information enabling targeted work with those GP Practices who are non-compliant or where quality requires improving. This is an ongoing piece of work that requires Primary Care to have full engagement with Think Family as the foundation. All Primary Care development work is now delivered with this foundational principle. The Joint Safeguarding Children and Adult Assurance Framework collated from GP Practices across Staffordshire on an annual basis provides auditable information pertaining to their standards, compliance, and application of safeguarding measures, including their approach to 'Think Family'. Areas of low confidence or knowledge in this area is identified and support offered.

7.4. The Named GP for Safeguarding Adults and Children incorporated 'Think Family' into training presentations from March 2021.

7.5. Within the 0-19 service, practitioners have been encouraged to attend multiagency training relating to child sexual abuse which is delivered by the safeguarding board. This was as a direct result of the shared information from the rapid review for Child I.

7.6. Children's Social Care are undertaking a review of training around sexual abuse.

7.7. Social workers have also been made aware of new training available from the NSPCC which will support professionals with understanding the theory, research, models, and approaches when considering the complexities with assessing the sexual risk to children. Children's Social Care will also share helpful tools and resources others can apply in practice as well as hear from some of the women who attended the programme. The aim of the workshops is to compliment, support and enhance the knowledge of all professionals' working in the Together for Childhood and surrounding areas, to prevent the risk of sexual harm to children. The workshops are: 1. Denial (types and purpose). 2. Beyond Grooming (how sex offenders operate). 3. The Good Lives Model (offender rehabilitation). 4. Protective Behaviours (working with children).

8. Other Reviews

8.1. Recent Child Safeguarding Practice Reviews: Beta[20] and Alex[21], have observed some similar practice areas for development by Staffordshire Safeguarding Children Board and its partner agencies, and as such the independent reviewer would suggest that the Board consider any overlapping when developing their action plan.

9. Review of Questions for Staffordshire Safeguarding Children Board.

[20] Published Child Safeguarding Practice Reviews - Staffordshire Safeguarding Children Board (staffsscb.org.uk)

[21] Not yet published.

9.1. In order to address the learning identified in this review, the review would ask the Staffordshire Safeguarding Children Board to deliberate the following questions.

9.2. It is the responsibility of Staffordshire Safeguarding Children Board to use the ensuing debate to model an action plan to support improvements to systems and practice.

1: How can the Staffordshire Safeguarding Children Board and its partner agencies strengthen practice around understanding the significance of family history, (particularly where there is a history of harmful sexual behaviour/abuse) and the importance of seeking information to understand any work undertaken to address its effects?

2: How can Staffordshire Safeguarding Children Board seek assurance that professionals from all agencies understand what specialist sexual abuse support services are available and how to access them?

3: How can partner agencies assure Staffordshire Safeguarding Children Board that work is being undertaken to signpost individuals with Sexually Problematic Behaviours and/or thoughts to support such as The Lucy Faithfull Foundation?

4: How can partner agencies assure Staffordshire Safeguarding Children Board that professionals from all agencies are informed of a 'Whole Family' approach and supported to include it within their practice?

5: How can Staffordshire Safeguarding Children Board obtain assurance that partner agencies are safeguarding children from potential risks when an individual is suspected of a crime (which could put a child at risk of harm), but a charge/conviction has not been possible?

6: How can Staffordshire Safeguarding Children Board ensure that work to improve Professional Curiosity identifies barriers preventing curiosity and helps professionals to overcome them?

Appendix 1

Key Lines of Enquiry:

- Are effective arrangements in place for individual agencies to obtain and share cross border information and historic information. And do agencies know where to obtain historic information (or is there an over-reliance upon Children's Social Care)?
- How do we share safeguarding concerns within a family to ensure a Think Family approach?
- How did professionals working with Child I gain an understanding of her wider family and the family culture?
- How is risk of inter-generational and inter-familial sexual abuse identified and managed?
- How did agencies ensure that the complex family circumstances were kept under review to manage the risk?
- Do we understand and effectively manage the potential risk of an alleged perpetrator of child sexual abuse who is not charged and/or convicted?
- Explore the assessment of risk and decision making in relation to Child Protection Processes, including information sharing between agencies and areas.
- How do we understand the lived experience and hear the voice of a non-verbal child?
- How did the Covid pandemic affect the care and support offered to Child I and her parents?