Working together to keep children safe

Staffordshire Safeguarding Children Board

Child Safeguarding Practice Review

Alex[1]

Agreed by the Staffordshire Safeguarding Children Board on 16.5.23

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1 Introduction

1.1 This review considers learning regarding the systems and practice within and between partner agencies in Staffordshire specifically in respect of children at risk of intrafamilial sexual abuse, by considering the children in a family where the father is a registered sex offender.[2] At the age of 12 Alex alleged sexual abuse from him, which had started when she was around six years old. He has since been convicted for this abuse.

1.2 Learning has been identified in the following areas:

- Knowing, sharing, and considering historic information when making decisions about the children of those with a conviction for a sexual offence against a child
- Child sexual abuse (CSA) often co-exists with other risks to a child, such as domestic abuse or neglect
- Need for support and specialist advice when working with families where there is a risk of CSA
- Understanding about perpetrators of CSA, including grooming behaviours
- The importance of schools in providing a safe space for children to be supported
- Out of hours responses to allegations of CSA

2 The process

2.1 An independent lead reviewer was commissioned[3] to work alongside a review group made up of local professionals. The group met on a regular basis to undertake the review and ensure that there was local ownership of the learning and recommendations.

[1] The child picked the name being used for the review.
[2] This status expired in 2021 but the alleged abuse happened while he was on the register
[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and Local Child Safeguarding Practice Reviews (CSPRs) and is entirely independent of the SSCB

2.2 Each agency that worked with Alex and her family were asked to provide chronologies including analysis and identification of single agency learning, and action plans are in place for the identified improvement actions required.

2.3 Professionals involved at the time were meaningfully involved in discussions about the family at two events held face to face in Staffordshire. This included an opportunity to reflect on the learning. They were also consulted about practice more generally and the systems that impact on the way that they work.

2.4 The lead reviewer and a representative of the Safeguarding Children Board met with Alex and with her mother. They provided information and their opinions to the review. Alex was seen again later to share the learning from the review and the recommendations. The lead reviewer and the Board appreciate her contributions and help.

2.5 This report has been written with the knowledge that it may be published. It only contains the information that is required to identify the learning. The sensitivity of the matter is clear however, and the decision regarding publication of the full report will be made only following full consideration by the Staffordshire Safeguarding Children Board (SSCB). The learning identified will be made public whatever the decision on publication.

2.6 In 2021, the SSCB completed a CSPR in respect of a child called Beta. There are similarities with this review, as a family member had a historic conviction for a sexual offence against a child, as well as a more recent conviction for child neglect. Like Alex, Beta disclosed sexual abuse within the family environment when she was a teenager, that had started when she was younger. The learning themes from Beta, that are relevant to this review are:

- The need for professionals to discuss risk with other agencies to ensure they understand the different risk assessments, the interface between them, and what the risk may be for a specific child.
- Children need to be central to processes. If adults caring for children have their own vulnerabilities, consideration should always be given to the impact on the children.
- Building trust, providing opportunities for children to disclose, and asking the right questions at the right time, is imperative to disclosure.
- The need for 'professional curiosity' and 'respectful uncertainty'.[4]

2.7 This review will consider this recent learning in respect of the professional response to the risk of and disclosure of sexual abuse within the family environment, as well as identifying any further learning from the consideration of Alex. It is acknowledged that the Beta review was not complete when the allegations were made by Alex, so there was limited opportunity for the learning to be shared and embedded by partner agencies. The learning from both reviews can therefore be used to increase knowledge and improve practice in this complex and difficult area.

[4] The Beta CSPR report states that professionals need to 'question everything', 'consider if what you are being told is true' and ask themselves if there 'is any evidence to the contrary that can be explored?'

3 Family information

3.1 Alex was living with her mother and siblings, and having regular contact with her father, when she told her friends at school that she had been raped by him. The friends told a teacher and Alex confirmed her disclosure and the extent of the abuse.

3.2 There had not been any significant concerns about the father following his release from prison in 2012. He had served a custodial sentence having admitted sexually abusing a 14-year-old girl. He was supervised under licence for a year following his release and he remained on the sex offenders register for ten years from the date of his conviction. This involved monitoring by a specialist officer in the police and certain restrictions which gradually decreased over time.

3.3 Alex's parents remained in a relationship following his prison sentence and went on to have another child. At the time of Alex's allegations, the couple had separated, and the father has not been living with the family since 2020. Due to the children's mother's work commitments, their father still spent time caring for the children in their home, and they sometimes stayed over at their father's accommodation. During her Achieving Best Evidence (ABE)[5] interview following her allegations, Alex told the police that she had twice told her mother that she was being abused; in 2015 and again in April 2022. She said that her mother stated that she would protect her but 'she didn't'. Mother told the review that she remembers Alex telling her in April 2022 that father had 'touched her boob'. Mother said she confronted father, but that Alex then retracted this allegation. She regrets not sharing this information with professionals at the time.

3.4 The family being considered are of white British heritage, as were most of the professionals working with them. The review did not consider the impact of wider 'social graces'[6] in respect of the family being considered but can reflect that this is a helpful tool for understanding a family's experience of working with professionals, the inherent power imbalance, and that it is a useful tool for understanding any difficulties in meaningful engagement.

4 Learning and analysis

4.1 The review has identified the following learning for the partnership and its partner agencies. The learning points identified are stated below, followed by the explanatory analysis.

Learning point 1
There is a need for detailed knowledge and robust information sharing in respect of any historic concerns and potential on-going risks when a known sexual offender is living with, or having contact with, children. All agencies must then ensure that this informs any work undertaken with the family.

[5] Achieving Best Evidence interviews are used when there is a criminal investigation, and a child is a potential witness. The interview guidance set out in ABE includes video-recorded interviews that can be played as evidence-in-chief in court. https://www.gov.uk/government/publications/achieving-best-evidence-in-criminal-proceedings

[6] John Burnham et al Development in Social Ggrraaacceesss (2012) meaning 'gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality'.

4.2 Following father's release from prison his licence stated he was to have no contact with anyone under 18 years old. A social work assessment was completed by Children's Social Care (CSC) and there was an agreement that his children could see him, but that they would be supervised by family members when their father was present. His licence was clear that he was a 'high risk' on release, and he was provided with accommodation separately from the family. The family was closed to CSC. Father was monitored by probation and police for the first year of his release, then by the police sexual offender management unit for the duration of his registration.

4.3 The review has found variations in the professional understanding of what risk father posed in the years since his sexual abuse of a child when he was 22 years old. It is the case that alongside the risk level being reduced over time, there was also a relaxation in the expected supervision of his children. This was because no new allegations were made, because there were not thought to be any specific concerns about the children, and because it was recognised that it was unrealistic for a father living with his children to be supervised all of the time. It was also acknowledged that because of the details of his offence, which was not thought to be as serious as the offences of other sex offenders due to the age of the child and father, and the fact that the victim was not related to father, there was less of a concern than there may be in other families. All of those involved, including those who work predominantly with sexual offenders, told the review that they look for signs of improvements and the lack of any known reoffending for father and his co-operation with professionals was seen as positive.

4.4 When father was sentenced, a risk assessment was completed, and it recommended that a custodial sentence should include him being referred to a core Sex Offender Treatment Programme (SOTP)[7]. On his release from prison, probation reported he remained at high risk of sexually reoffending. He was on licence for 12 months and had an allocated probation officer. During that year there were restrictions on him, including curfews. Father worked with the probation service, including completing the Better Lives programme[8]. It was recorded at the time that he 'presented as strongly engaged'. Towards the end of his year on licence, father's risk level was reduced by probation from being at high risk of serious harm to children to being at medium risk.

4.5 Father remained on the Sexual Offenders Register until just before his daughter made the allegations about him in 2022. He was not made the subject of a Sexual Harm Prevention Order when convicted, which limited some of the conditions and restrictions that could be imposed. However, he did have contact with the Staffordshire Police Sexual Offender Manager (SOM) for the remainder of the ten years. SOMs are responsible for managing sexual offenders in the community, including active risk management. In this case, the SOM visited father both at his own address/es and at the family home, as they were aware that he spent time there providing childcare for his children following the couple's separation. These visits were generally unannounced and were undertaken as part of the ongoing risk management process. There were

[7] He completed this work while in custody and then in the community, which was what was expected at the time.
[8] A cognitive-behavioural programme focussing on emotions, forming appropriate adult relationships and developing a relapse prevention plan that was being used at the time.

several officers in the role over the course of the registration period, which avoids the risk of familiarity impacting on recognising disguised compliance or manipulation. The most recent SOM attended the meetings held for this review, and they knew father well. They had a full knowledge of his offence and the risk assessment completed by probation which had preceded their involvement.

4.6 Over time the plan put in place following father's release from prison changed, with a CSC manager in 2015 stating that the previous arrangement for father to always be supervised while with his children was 'out of date and unrealistic'. The context to this decision was that CSC had agreed, generally, that written agreements were ineffective and should be avoided. The children had been closed to CSC previously, with a written agreement in place stating that the children's mother would supervise all contact. Several Serious Case Reviews around this time had criticised the use of written agreements as not being effective and providing a false sense of security to professionals, while not protecting children. This was particularly the case where there was domestic abuse. The National Director for Social Care at Ofsted said following a thematic Joint Targeted Area Inspection (JTAI) in 2018 that written agreements in domestic abuse cases can be 'tantamount to victim blaming' and are at best ineffective. The JTAI showed that written agreements should only be used if they are 'underpinned by thorough assessment that is clear about risk and protective factors of all relevant adults and family members', and that there must be 'clarity on how the written agreement will be monitored and reviewed in accordance with multi-agency plans and how this will inform the assessment of risk and action taken'. While domestic abuse was not specifically identified in this family, mother told the review that both her and the children were wary of him, as he would often get angry and could be controlling. She described him as the parent who was 'strict', and that she relied on this to a certain extent. As there are some similarities between the perpetrators of domestic abuse and child sex abuse, the use of written agreements in such cases are also likely to be ineffective.

4.7 For Alex there was a review of the children's contact with their father by CSC following the school asking about the situation, as they had observed father collecting the children from school on his own. It was agreed by CSC that the requirement for constant supervision be 'relaxed.' They told the review that they made this decision after a conversation with the police SOM, who confirmed there was no requirement for him to be supervised with his own children as far as his registration was concerned, although he remained a medium risk offender until the end of his licence period. There was also a conversation with mother that reinforced that she needed to remain cautious and that he may remain a risk. Probation was not involved at the time but told the review that there is an information sharing process that children's services can use to request information if the case is closed to probation, or if the previous probation officer was no longer working in the organisation. In this case they would likely have reflected that he had done well while on licence, had not reoffended, and was a low risk as far as they were concerned. So, if they had been contacted it is unlikely that the decision made by CSC at the time would have changed, as it was proportional and pragmatic.

4.8 There were some professional concerns in the period before Alex's allegations. The primary school made a referral in 2015 after a bruise was seen on then six-year-old Alex's head. She told school staff that her father had been angry and pushed her and that she hit her head on a door. A single agency CSC investigation was completed with no further action. There is evidence on the children's CSC record of liaison with the SOM who confirmed that they were aware that father was living back with the family and that this was permitted despite him being a registered sexual offender, and that he remained medium risk at the time. Mother stated she continued to supervise the children's contact with their father. She was told shortly after that this was no longer required. It is now known that mother relied on father to care for the children while she worked in a job not confined to school hours, with this arrangement continuing after they separated in April 2020.

4.9 The following year (2016) the school made a further referral as they had concerns about Alex's behaviour. They stated she was 'unable to sit still in class and fidgeting, with constant and excessive rubbing of her genital area'. She was also observed to put a pencil between her legs on several occasions. The matter was not considered at a strategy meeting, but a social work assessment was completed. The assessment found that mother minimised the seriousness of father's offence, so there was a period of child in need planning which included 'keep safe' direct work with the children. Alex told the review that she did not remember the sessions and did not consider it as relevant to her at the time, even when she was being sexually abused. She said that her fear of disclosing, worries about how angry her father would be with her, and not knowing what would happen next, were the main reasons she didn't tell sooner.

4.10 The children's mother reported, at the time, that the previous month Alex had been sore in her genital area and had been taken to the GP, where she had been examined. She told the review she believed it was due to a change of fabric softener. The GP surgery where the whole family are currently registered told this review that the children's records do not state that they were living with or had contact with a sexual offender. This lack of important information limits a doctor's ability to see any health concerns through a safeguarding lens. Later, when the children were subjects of a child in need plan, the GPs are not informed or spoken to. This is a system vulnerability, and the review group agrees that information should be shared with a child's and a parent's GP when a child is the subject of a children and families social work assessment or is the subject of a plan. This is not common practice, so a recommendation has been made to respond to this learning.

4.11 At the request of the GP, Alex was seen by a community paediatrician. The letter that summarised the assessment undertaken was then copied to the GP. It implies that there was some awareness of father's history, as the letter stated the paediatrician was told by mother that she always supervised the children with their father. The letter did not explicitly say why this was, and this does not appear to have been clarified with any other agency. There were no concerns from the medical examination, which included an intimate examination. The review noted that it appears father was present for this examination, which is a concern. The panel was told that this has been

discussed with the professionals involved at the time and that a single agency action plan is in place to ensure that this does not happen again.

4.12 It was good practice that the school identified this concerning behaviour in Alex, as it may have indicated sexual abuse. They were aware of her father's history, which made them alert to any behaviour of concern. They also understood the importance of sharing this with CSC. The systems in which professionals work mean that there is an over-reliance on a child disclosing sexual abuse to enable them to be safeguarded. However, evidence shows that children are unlikely to make an allegation, particularly when the perpetrator is a close family member. In 2015, the Children's Commissioner carried out an inquiry into child sexual abuse in the family environment[9]. They reported that around one in eight children who are sexually abused are identified by professionals, and that while the police and local authorities recorded around 50,000 sexual abuse allegations over the two years to March 2014, it is estimated that as many as 450,000 children were likely to have been abused over the same period. It was also noted that children themselves often do not recognise that they have been abused until they are older. It is positive that keep safe work was undertaken with Alex, however as a child grows and develops there is arguably a need to repeat this work in an age-appropriate way. This does not tend to happen, partly due to limited resources but also due to a fear of retraumatising children who may have been abused in the past.

4.13 The CIN plan was in place for around five months and then Early Help provided further support and direct work to mother and the children, until October 2017. There was helpful reflection from the early help service that they could have done more in respect of keep safe work as part of their interventions at the time, perhaps building on and as a reminder of the previous input, which had been some years before. Both mother and Alex were asked about their memories of the keep safe work and other education and interventions over the years. Alex had little memory of any input prior to secondary school, although she remembered PANTS. She said that she didn't really think it was relevant to her at the time. She did add that if she had, she may not have told, as she would have been scared about how angry her father would be and her fear of what would happen if she did tell. Mother said that the benefit of historic work completed was limited over time, mainly due to her own issues, including needing to work long hours and manage her mental health. There is a need to keep the keep safe messages on the agenda for families where a sex offender lives with or has contact with the children.

4.14 The professionals spoken to as part of the review shared that they can now see there is a need to clarify with other professionals if they have unanswered questions or a lack of clarity about the risk a parent may pose. They stated that if they 'don't know' or 'wonder', they can see that they need to take advice from those who are likely to have more experience or expertise in this area of safeguarding. This is good advice; however, it is acknowledged that Alex's father was manipulative and able to reassure professionals that his offending was in the past.

[9] Protecting children from harm: A critical assessment of child sexual abuse in the family network in England. 2015.

Learning point 2
When there is a significant change in a family where there is a known risk of sexual abuse, there is a need for a multi-agency reconsideration of previous assessments and the level of risk. This should include an update on other vulnerabilities, such as concerns about domestic abuse or neglect. Time should also be taken to hear the voice of the child and understand how this change has impacted upon the child's lived experience.

4.15 In 2018 the police SOM informed CSC that mother was expecting a third child and recorded that 'further assessments are required to consider changes in family circumstances and mothers' ability to ensure that father is not having 'unsupervised contact'. There is evidence that pregnancy and a new baby can increase the risk of sexual abuse, and it was good practice that the change of circumstances was shared with CSC. The opportunity was not taken to reassess the family and any potential additional risks at the time, however. The social work manager who made the decision told the review that there had been a conversation with the SOM who said they were referring it as a 'tick box exercise' and that they were not concerned, which is why there was no reassessment. The CSC manager involved had been in the team for several years and knew the family. They said that it is not uncommon to receive notifications rather than referrals, and it appears this was what happened here.

4.16 The earlier and ongoing risk assessments of father, completed by probation and known by the police SOM, had highlighted that the lack of an intimate relationship increased his risk of reoffending. Whenever there is a change of circumstances in a family where there is any risk of sexual abuse, there is a need to undertake a reassessment, both in respect of the potential perpetrator, but also of the capacity of the 'protective' parent to protect. It is understandable that professionals working more generally with children may not have the skills and experience to understand and fully consider these issues, and the review has found a need for there to be better communication between those working with or responsible for children and those who work regularly with sexual offenders. When circumstances change, there is a need to reassess the risk to the children, including ensuring that the details included in past assessments are considered. This is like the learning identified in the Beta review, that stated the need to consider risk with other agencies to improve understanding of assessments and what the risk may be for a specific child. It is also the responsibility of those working with adults to challenge professionals with responsibility for children if they do not act when a request is made for a change of circumstances or new information to be considered.

4.17 In 2019 the SOM visited father at the children's home and found him looking after his own children but also two of their young friends. It was confirmed by both the police and CSC, at the time and for the review, that while there were no restrictions on father's contact with his own children it had been made clear to him that he should not have unsupervised contact with other children. Action was taken, but this did not include a reassessment of father's risk to his own children, despite him not meeting expectations in respect of his contact with children. Mother told the review that she

had convinced her friend that father was a good person and could be trusted, and that she now regrets this.

4.18 A Triennial Review was published in 2022[10]. It states that safeguarding children in cases involving sexual abuse is 'difficult and daunting work, and professionals will need training, time, resources, and supervision to be effective.' It includes a specific section on sexual abuse in the family environment, and suggests that re-offending was common, and that 'when known perpetrators are living with families there should be robust up-to-date risk assessments, which are regularly reviewed particularly when new information becomes available. Information should be shared with relevant professionals working with such families, so that they can be alert to any potential signs in children, particularly as they rarely disclose abuse directly.' This is relevant to Alex.

4.19 There were also concerns shared about shouting and arguing in the house, which may have indicated threatening behaviour to the children and/or domestic abuse. This is considered further below.

Learning point 3
There is a need for all professionals to understand the complexity of working with families where there is a risk of sexual abuse. They need support and access to specialist advice.

4.20 Child sexual abuse within the family often co-exists with other forms of abuse and where there are vulnerabilities for the children and/or potentially protective adult. Further concerns about Alex and her sibling's lives emerged during 2020 and 2021. Anonymous calls were received by CSC that shared concerns about father's treatment of the children, and to a lesser extent mother. When spoken to, mother stated that the information was untrue, and it was accepted that the referrals were 'malicious'.

4.21 There were other issues that now appear to be significant that were not shared at the time. This includes Alex's younger sibling telling the school in 2020 that when they stay over with their father, Alex shares a bed with him. The school discussed this with both parents and shared their view that it was inappropriate. The school also reflected on the child's recent behaviour and were reassured that there had been no concerns. There had recently been input from Childline and a workshop that Alex attended, and they specifically monitored her during and after the event and were reassured that she seemed fine. The information about the bed-sharing was not shared with CSC as the family was closed to them at the time, and the school did not think there would be any action taken if they did refer it. The information was not shared with father's SOM. The latter told the review that they would have been concerned about this information and would have challenged father about this.

4.22 The children's mother was hospitalised in May 2021 following an overdose of paracetamol and wine. She called an ambulance while caring for the children to report what she had done. Mother was assessed in hospital and on her discharge and was supported by both her GP and by adult

[10] https://scr.researchinpractice.org.uk/media/6790/learning-for-the-future-final-analysis-of-scrs-2017-19-2022.pdf

mental health services. The assessment completed by a nurse in the well-being service led to a referral and information sharing with CSC due to mother's report that the children were being cared for by their father, a convicted sexual offender, while she was in hospital. This was good practice. Over the next few weeks mother did not engage with the mental health support and was discharged from the service (again there was information sharing with CSC in respect of this.) There was also limited engagement from mother with the GP surgery's attempts to see her. The early help plan closed due to 'improvements' which is a tick box choice. This may not entirely reflect the position at closure. The early help tasks would have come to an end, and while it did not take into consideration the wider lack of cooperation with support, there was a need to close their involvement as support is not designed to be long term. The housing provider reported that they were happier with the state of the outside of the home and that there had been no further complaints from neighbours. It was known at the time that mother was not entirely engaged with Early Help, but there were no specific tasks that required continued involvement.

4.23 Towards the end of 2021 the housing provider shared concerns about the family with CSC. They had visited as neighbours were concerned that the home was unkempt and because the children were often being shouted at by their mother. The referral to CSC included concerns directly observed by the housing officer about the condition of the property. The referral led to the involvement of an early help professional from September 2021 to March 2022. The focus of the work to be undertaken was; the impact on the children of mother's poor mental health; the home conditions; debt and financial concerns; the need to explore potential extended family support; parenting support; and 'wishes and feelings work' with the children to gain an insight into their lived experience. An initial team around the family meeting was held that included the primary school and both parents. A follow up meeting was also arranged, but cancelled on the day as the parents did not attend. The decision to close was made shortly afterwards, and learning has been identified about the need to discuss this with professionals involved in other agencies to ensure they are aware and are able to challenge the decision if they feel they need to.

4.24 There is a relationship between neglect and intrafamilial sexual abuse. The NSPCC and Action for Children with Research in Practice investigated this, and what they found resonated with those involved with Alex and her family[11]. The investigation found that the impact of neglect can *'interact with other factors and adversities in a number of ways to increase young people's vulnerability to harm.'* This includes vulnerability to sexual abuse. They therefore suggest that practitioners working with children and families where neglect or sexual abuse is a concern should *'sensitively investigate the potential for co-occurring and cumulative forms of harm',* and that *'practitioners should be alert to negative, invalidating responses from families to disclosures of sexual abuse'.* For Alex, there were concerns shared about the state of the home. An EDT social worker visited after mother took the overdose and there was no bedding on the children's beds. Mother had spoken to IAPT and early help about lack of money and stress due to debt, and this appears to be

[11] Elly Hanson, Debbie Allnock and Simon Hackett (2016)

reflected in the state of the home. Housing also shared information about the conditions. It can now be seen that these concerns may have indicated a vulnerability to harm beyond neglect.

Learning point 4
It is important that professionals do not dismiss anonymous or non-professional reports or referrals without full consideration.

4.25 Using the term 'malicious' is a powerful statement and can lead to professionals no longer pursuing the concerns. Even if there is evidence that the referral was being made to cause trouble, it does not mean that it is untrue or that there are not elements of truth in the concerns shared. Professionals always need to consider BOTH whether information shared is given in good or bad faith, **and** whether it might be accurate. This is because it is possible both for good faith information to be inaccurate (mistaken for example) and bad faith information to be partially or completely accurate (for example real concerns reported to be vindictive)[12]. Checks should also include consideration of seeking the voice of the child. For Alex, mother's insistence that referrals were made to cause trouble were accepted. She told the review that there were domestic abuse incidents, but that she had not been able to speak about them at the time due to feeling intimidated by the children's father.

4.26 The 2022 national review into the deaths of Star Hobson and Arthur Labinjo-Hughes 'Child Protection in England', stated the need for robust consideration of any referral that the family claim is malicious or shared to cause trouble, and that the information shared should not be deemed 'malicious' without a 'full and thorough multi-agency assessment'. The review states that this should include 'talking with the referrer, and agreement from an appropriate manager'. They would like to see the end of 'malicious referral' in professional safeguarding terminology. This review is a good example of why this might be helpful. Checks were completed with the schools (there were no new concerns) and no further action was taken. The use of anger as a form of grooming and control was not considered.

Learning point 5
Schools are essential partners when it comes to providing a space for children to be safe and gain support if they are experiencing abuse or neglect.

4.27 Alex told the lead reviewer that she would advise any child being abused to tell a friend or safe adult at school. A report published by the NSPCC in 2023 summarised the learning from CSPRs published during 2020-2022 specifically for the education sector[13]. It shows that schools are often the place where indicators of abuse are spotted, and where children choose to disclose concerns. Teachers are often in a good position to notice warning signs and take appropriate action to prevent things getting worse or provide help and support. Alex's primary school noted concerning

[12] Writing Analytical Assessments in Social Work, Chris Dyke. 2016.
[13] Education: learning from case reviews. Summary of risk factors and learning for improved practice around the education sector. NSPCC. February 2023

indicators of sexual abuse and shared these. As it is acknowledged that while very few children are likely to make a disclosure, professional curiosity alongside an understanding that sexual abuse does happen and may impact on a child's behaviour, is essential and was shown by the school. Without either medical evidence or a disclosure from the child however, the abuse was not identified around the time that it was likely to have started. Preventative awareness work was however undertaken with the older children and their mother.

4.28 The 2023 NSPCC report highlights that schools sometimes struggled to get the information or support they needed to keep children safe or did not share the information they had with the relevant people or agencies. The reviews found that this made it harder for schools to 'understand the full significance of potential concerns identified during the school day.' Good communication with a child's school means that other agencies can consider the impact on the child of any concerns there may be about their experiences at home. Regarding Alex, there were often conversations with the primary school by social workers about how her and the middle sibling presented, and an awareness from the school that they needed to monitor how the girls were in school. Mostly they seemed well and happy.

4.29 There has been a lot of work across schools in Staffordshire in respect of them taking a more proactive role and the expectation that they speak to children about changes in their circumstances, for example parental separation or a bereavement. It was noted during the review that Alex's disclosure came around the time that she was receiving input at school in PSE classes about healthy relationships. The classes resulted in a lot of children speaking amongst themselves about what was discussed, and this too may have had an impact on Alex's decision to speak to her friends. More generally, secondary schools are placing a greater emphasis on having safe spaces for children who need them, and making sure a child has an adult they can build a relationship with and speak to. This was evident in the excellent support provided to Alex when she was seen in school for the purpose of this review. While this shift is largely about preventing and responding to mental health issues, this will also benefit children that are vulnerable in all ways.

Learning point 6
Professionals working with children and families need to have adequate and appropriate knowledge about perpetrators of intrafamilial sexual abuse, to consider risks and to challenge families and each other.

4.30 Following the 2015 Children's Commissioners report, a JTAI was undertaken then published in February 2020. The aim was to consider how professionals work together in cases of intrafamilial sexual abuse and involved a national sample of local authority areas.[14] The JTAI found that there was a lack of professional confidence when it came to sexual abuse in a family environment. In other cases, misplaced confidence was seen, where plans were being made for children without fully understanding the risk from the perpetrator. These same issues were seen in respect of those

[14] Multi-agency response to child sexual abuse in the family environment: Joint Targeted Area Inspections - 4 February 2020

working with Alex and her family. The social worker involved following mother's overdose apparently told the mental health service that it had been assessed that the father posed 'no risk' to his own children, and that he had been 'a young care leaver' when he 'had sex with a 15-year-old'. This minimised both his sexual abuse of a 14-year-old child, the potential ongoing risk to his own children (although this was considered to be low) and his higher risk to other children.[15] Professionals must challenge this thinking and terminology from themselves and colleagues and be aware of the risk of concerns being diluted over time. The review found that there is a need for professionals to have access to historic assessments, probation expertise and information, and good information sharing with the SOM service to avoid this, particularly when there are changes of services and of those allocated to a particular child/family. It is acknowledged that it is difficult, over time, to maintain a complete understanding of historical concerns, particularly when the perpetrator is determined to mislead professionals, as was the case here.

4.31 Perpetrators of sexual abuse are known to groom children, family members and professionals. The 2020 JTAI concluded that it is essential for professionals to be aware of how sexual offenders operate. They found that professionals working in childcare roles *'are not equipped to know enough about perpetrators of child sexual abuse in the family environment: how to identify them, what their escalation patterns are and how to prevent them from abusing children'.* Those working with Alex and her family told the review that they had largely been taken in by her father, and their shock at hearing about the abuse and the timeframe of the allegations was very evident. There was a degree of distrust from the primary school staff, who saw father very regularly. It is important for information to be sought from and shared with schools or other agencies that see parents on a regular basis, and particular emphasis should be given to what this brings to any assessment.

4.32 Child sexual offenders can present in numerous ways that professionals need to be aware of. They can be plausible, needy, or intimidating. They often work hard to gain the trust of practitioners by being charming or appearing insightful. They may cooperate with all that is asked of them or skillfully avoid professional scrutiny. They can encourage people to feel sorry for them, try to convince people that everyone is against them, and they can blame the child/victim. In the case of Alex's father, it appears that he was able to convince the children's mother that he was not a risk and was able to groom Alex to the extent that she did not tell for many years. What is clear, is the extent of father's manipulation of both his victim, her mother, and the professionals involved, including those who are experienced and skilled in working in the area of sexual offending.

4.33 The review considered how professionals can be supported when working in this complex arena, and it was agreed that peer and supervisory support is required to regularly consider if they or others are being groomed. Professional supervision and challenge is required to ensure there is a positive impact on those having to consider the risk to children from having contact with a sex offender. Staffordshire Police are now training officers working in sex offender management to

[15] The specific social worker was not engaged in the review as they no longer work in the area, but it was acknowledged that this is potentially learning for the wider system issue and needs to be noted.

understand the links between sexual offending, volatility, and domestic abuse by using the MOSOVO[16] model. An understanding of this would also be helpful across other agencies.

4.34 In all areas of safeguarding work, professionals can lose focus on the child and instead prioritise the needs of a parent whose own needs are extensive or complex. This is particularly the case when working with a family where there is a risk of sexual abuse from a family member, as the level of potential manipulation is likely to be high. Several of the professionals involved with Alex had not knowingly worked with a family where sexual abuse in the family environment was the main concern before. Inexperienced staff require training and support, which includes supportive challenge, if they can then safeguard children at risk of CSA. Direct engagement with the children is also important, although it is acknowledged that there was evidence of social workers and the family support worker meeting the children at home and at school, with no concerns identified.

4.35 Professionals can also find it difficult to engage with and support the 'non-abusing' parent. This requires significant knowledge of the relationship between the couple, and the non-abusing parents' own vulnerabilities, if there is to be robust on-going awareness of their understanding of the risk and their capacity to protect. There is often a dependency of the non-abusing parent on the offender, which impacts on their ability to protect their children and leave the relationship. It is complex and difficult work to undertake and requires specialist support and supervision. When the non-abusing parent has their own vulnerabilities, such as Alex mother's mental health issues, this also needs to be taken into consideration. There were also some potential indicators of domestic abuse, including information shared by neighbours. The Early Help worker and the mental health professionals identified that mother was reliant on father to care for the children while she worked, and that she felt he took advantage of her financially. Despite them having separated, he spent a lot of time at the family home, including when Mother was home, and seems to have dominated many of the professional engagements. Both parent's engagement with early help was intermittent, but with no specific increased concerns to lead to the service 'stepping up', the family was closed to early help.

Learning point 7
The COVID-19 pandemic has had an impact on families and on the ability of professionals to respond.

4.36 There were places offered in school to these children during the national lockdowns, but the family chose not to send them. The older children were 'home schooled' between March 2020 – September 2020 and again in January – March 2021. The review was told that father largely took responsibility for this, as mother continued to work during the government lockdowns in a key worker role. Free school meals and work was delivered each week to the doorstep of the family home, and both girls were seen during on-line learning sessions (the school provided a laptop as the middle sibling has an education, health and care plan (EHCP), and she was seen frequently

[16] Management of sexual offenders and violent offenders

on computer due to 1:1 sessions). Despite these attempts to continue to see the children, there was nowhere near the oversight that full time school provides. There was also little or no time away from the home from the children's point of view. By 2021, when the social work assessment was completed following mother's overdose, there was no COVID-19 impact on service provision.

4.37 In August 2020 the NSPCC published a briefing paper on the impact of the pandemic on child sexual abuse[17]. It provides information from Childline and the NSPCC helpline. The briefing states that there has been a threefold increase in the number of calls about CSA within the family and that some children said that sexual abuse had become more frequent during lockdown, as they were spending more time with their abuser. It concluded that the restrictions exacerbated the risk of CSA, providing perpetrators with more opportunities to sexually abuse children in their family.

Learning point 8
When out of hours services are involved following an allegation there is a need for robust and timely information sharing with those who will be responsible for ongoing investigation/s and provision of services.

4.38 A specialist medical was arranged and undertaken on the day that the allegations were made, in the hope that forensic evidence would be gained. As the allegations were made on a Friday, there was a need to ensure the protection of Alex and her siblings into the weekend, and a need to progress the criminal investigation over the days immediately following. This means that a key part of the investigation happened 'out of hours'. A strategy meeting was held on the Friday and a plan was made to interview Alex and her sibling using the ABE joint agency process on the Monday. Over the weekend this plan changed, with the police going ahead with the interviews without a social worker being present.

4.39 The structure of the police service in Staffordshire had an impact on what happened. The police officers in the Multi-Agency Safeguarding Hub (MASH) coordinate and attend initial strategy meetings, but they are not then part of the operational team that will then continue the investigation. The officers involved in the ongoing investigation told the review that they would have been very unlikely to agree that the ABE interviews were delayed until the Monday, and that it is not appropriate for a MASH police officer to make this decision. There is therefore learning for Staffordshire Police in respect of information sharing between the officers in the MASH and those who will be involved going forward. If this is a wider issue, there will be other cases where multi-agency decisions made during a strategy meeting will be changed and this not always being discussed with or communicated to partner agencies. There is a plan to restructure both the MASH and the police response to child abuse in Staffordshire, and that this systemic issue will be addressed.

4.40 It was acknowledged that asking CSC Emergency Duty Team (EDT) to provide a social worker over the weekend would have been helpful. The absence of this request for Alex may in part be

[17] https://learning.nspcc.org.uk/media/2280/impact-of-coronavirus-pandemic-on-child-welfare-sexual-abuse.pdf

due to the police knowledge of capacity issues for the CSC EDT service, where there are sometimes difficulties in providing a social worker on a weekend. While it is not essential that CSC are represented in ABE interviews, this can create issues in respect of the ongoing involvement and the need for them to have to 'catch up' afterwards. The review was told that there were delays in the responsible social worker getting transcripts of the interview, which had an impact on their ability to fully understand the allegations made to help with care planning, supporting the child, and ensuring they understood the role of the mother, as Alex said she had told her mother about the abuse.

5 Conclusions and recommendations

5.1 The Children's Commissioner said in 2015 that 'the most common form of child sexual abuse takes place behind the front door within families or their trusted circle.' 'Many victims suffer in silence, unknown to those who could protect or help them to overcome their experiences. This is often because the services we provide rely on children coming forward and telling someone that they have been abused, which they rarely do'. This could be because they 'feel intimidated, scared of causing trouble for their family, or simply not have the words to express what has happened to them.' Alex disclosed to her friends, who then told a teacher. Otherwise, it is likely that her abuse would be ongoing. This is a challenge for professionals and the systems in which they work.

5.2 The rapid review that started this process recorded their hope that professionals would gain an understanding of how others work and how their roles interact. Those professionals who knew the children and met as part of this review acknowledged they had not realised what it involved when a parent is a registered sexual offender, the extent of the assessments undertaken and ongoing, and the need to reassess at times with full knowledge of what the risks are (specific to the case as well as just a statement that risks are medium or low). It is a hope of all of those involved that all professionals would benefit from this particular insight. The particular and high vulnerability of any child who is living with a sexual offender is shown by this review, as it was in the Beta review.

5.3 Sexual abuse in the family environment is being considered in Staffordshire due to the Beta review and other work being undertaken. Practice is developing in both the single and multi-agency context. The review was told that school designated safeguarding leads have received a briefing specifically about child sexual abuse and the potential signs. The session included speakers from the NSPCC, and the Lucy Faithful Foundation.

5.4 The consideration of professional engagement with Alex and her family specifically has led to learning for both individual agencies and for wider systems and multiagency practice. It has also identified evidence of good practice and committed professionals who worked hard with the family and who were committed to safeguarding Alex and her siblings, despite the challenges.

5.5 Extensive helpful single agency learning was identified during the review. For example, the need for single agency work to know and consider the history of the family, including the details included in risk assessments undertaken by another agency. The importance of extended family and how they can be engaged to provide support and safety, as long as a robust piece of work is

undertaken to engage them and ensure they understand the risks. And the need for professionals working with children to have a good understanding of the role of professionals working with sexual offenders and improved links to discuss specific offenders, as required.

5.6 The single agency chronologies completed by all the agencies involved in the review include a number of recommendations to address the need for improvement action, including single agency SMART action plans which will be monitored by the Safeguarding Partnership.

5.7 Having considered the learning that has not been addressed in the single agency actions, the following additional recommendations are made to ensure improvements. There is an expectation that the learning from the review is disseminated widely both by partner agencies and the Board.

Recommendation 1:

That the SSCB asks partner agencies to ensure there is a focus for the whole system on the development of staff to enable them to work with children where sexual abuse in the family environment is an issue. The work is complex and different to other child protection work, and professionals require -

- access to training including around perpetrators within the family environment and understanding/or and assessing risk
- supervision and/or peer or management support, including consideration of the impact of the work[18]
- a local arrangement where front line professionals have access to a named person with knowledge and expertise of sexual abuse in the family environment, who can provide consultation as required.

Recommendation 2:

That the SSCB informs the relevant partner agencies of the expectation that they robustly consider their response when concerns are shared by a person who is not a professional, with the expectation that these are given equal weight, and that responses include hearing the voice of the child.

Recommendation 3:

That the SSCB seeks assurance about the mechanisms in place across the relevant partner agencies that ensure that decision making considers previous assessments and the family history that is available in their own agency and in other agencies.

Recommendation 4:

That the SSCB inform CSC that they must implement the requirement for information sharing with the GPs for children and for their parents when a child is the subject of a plan or when an assessment is being completed[19]. The Integrated Care Board (ICB) to be informed that they must

[18] Both the longer-term impact of the work, but also timely support for those responding to a child disclosing abuse to them.
[19] Either S47 or S17 of the Children Act

work with GPs so that they are aware of the expectation that they cooperate with this change in practice.