Working together to keep children safe

Staffordshire Safeguarding Children Board

Local Child Safeguarding Practice Review (LSCPR)

Final Report

Child I

Independent Author: Allison Sandiford

Contents

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[1] 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[2] 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[3] 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[4] 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] Child Safeguarding Practice Review Panel - GOV.UK (www.gov.uk)

[2] 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

[3] Refer to Appendix 1

[4] Children's Social Care, Three Schools, School Nurses, Police, Community Midwifery, Health Visitors, Child Protection Chair, and Staffordshire Safeguarding Children Board.

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 Child Safeguarding Practice 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[5] were both 22 years of age at the time.

4.2. Mum has four older siblings and seven younger siblings. Mum's mother (Child I's maternal grandmother, hereafter known as MGM) has sadly passed away post the scoping period of this review. Staffordshire Safeguarding Children Board and the Independent Reviewer offer their condolences to the family. Professionals who have worked with the family report that it was usually Mum's father (Child I's maternal

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

grandfather hereafter known as MGF) who communicated with them and that it was difficult to see any of the children without him being present.

4.3. Mum's family are known to have previously lived in Staffordshire, but they moved to the South West of England in 2007 and then to another location in the South West around 2010. In 2011 they moved again where it seems they stayed until 2017 when they relocated to West Yorkshire. It is known that children of MGM and MGF were subject to child protection plans in both the South West and West Yorkshire. Children's Social Care had planned to issue care 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 in that local authority area 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[6] 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 Staffordshire 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, and this is detailed later in the report.

4.7. Child I's Dad was subject to Care Orders between the ages of 13 and 18.

4.8. Dad has 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. His family do not reside in the Staffordshire area, 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 his mother accused him of inappropriate sexual behaviour with his younger sister when he was a teenager. Dad denies these allegations.

Summary of Events within the Scoping Period

4.9. Mum booked her pregnancy with the Community Midwife at 26+2 weeks gestation. Mum reported a history of depression but there is no record of any concerning information regarding her history, or that of

[6] 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.

her wider family or Dad's wider family, being shared. Consequently, no maternity safeguarding alerts were required to be raised.

4.10. Child I was born in hospital and was discharged the following day to her maternal grandparents' address. Mum usually resided in supported accommodation[7] with Dad, however, following the birth of Child I, they moved to Mum's parents address temporarily, reportedly for support.

4.11. The midwife notified the health visitor of this, and Child I was seen at the address by a health visitor within timescale. Mum informed the health visitor that she had previously suffered depression and anxiety but assured that the depression was resolved, and that she was able to manage her anxiety with support from her partner and family. A universal mental health assessment was carried out with Mum. The score did not give rise to concern as it was under 3. Any score above 3 would have required further assessment.

4.12. When Child I was 6 weeks old, Mum and Dad presented her at the hospital and reported that she had been screaming. It was decided that Child I had become unsettled with milk changes, overfeeding and colic.

4.13. The health visitor further visited Child I when she was 7 weeks old. There were no concerns at that time, but within weeks health were informed that Children's Social Care, were gathering information about Child I. Children's Social Care had received a referral from the Special Education Needs Support Services Assessment Planning Team, with whom two of Child I's aunts and an uncle were in receipt of two hours home tuition a day. Since December 2019, MGF had cancelled over 40 of the sessions and two tutors had reported that MGF had threatened to 'slap' the children during video calls. Following the referral, section 47[8] enquiries deemed it necessary to complete a section 17[9] Chid in Need Assessment in respect of Child I, as well as the aunts and uncle, as Child I was living at the same address at the time with Mum and Dad.

4.14. The Child Social Work Assessment commenced with the key concerns for Child I's aunts and uncle being noted as:

- Lack of education.
- Children not being visible to professionals.
- Overcrowding at the family home.
- Concerns regarding one aunt who was self-harming.
- Children not being registered with health services.
- Concerns regarding maternal grandparents' eldest child being a Person Posing a Risk to Children due to sexual abuse offences.
- Information on the files also suggested a history of disclosures regarding allegations of sexual abuse incidents between the siblings.

4.15. Child I's assessment included exploration of Child I's wider family and established that Mum considered her childhood to have been positive. Mum informed the social worker that she would not have any contact with her older brother who was known to pose a risk to children and that she would protect Child I from

[7] This review has been unable to establish why they were living in supported accommodation.

[8] Under the Child Act 1989, a Section 47 enquiry is carried out to ascertain if any and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

[9] Section 17 of the Children Act 1989 imposes a general duty on local authorities to safeguard and promote the welfare of "children in need" in their area.

anyone in her family who acted inappropriately or was abusive. Dad disclosed his family history, and the social worker discussed the alleged sexual abuse against his younger sister[10]. The Child Social Work Assessment noted that *although wider concerns have been identified around the failure to meet the health and educational needs of other children within maternal grandparent's home, it is not felt that these concerns are likely to directly impact Child I at this time.* The assessment concluded that the worries for Child I included Dad's offending history, Dad's mental health, parents' historic substance use and the current overcrowded conditions at maternal grandparents address. However, there were no concerns for Child I's basic care and maternal grandparents were seen as providing emotional, financial, and practical support in a stable home environment.

4.16. Child in Need plans were recommended for Child I and the aunts and uncle concerned, but Mum and Dad declined consent for a Child in Need plan. They did agree to a referral to Early Help. Child I was then closed to Children's Social Care.

4.17. By this time the United Kingdom had entered lockdown due to the Covid pandemic. The effect of the Covid pandemic upon the care and support afforded the family is considered later in this report.

4.18. In September 2020 a strategy discussion was held regarding the aunts and uncles subject to Child in Need as, due to MGF always being present, professionals were proving unable to complete direct work with the children. In addition, MGM would not allow professionals to enter the address if MGF was not present, and there were concerns for missed health appointments and education. It was agreed to proceed to an Initial Child Protection Conference.

4.19. At the beginning of the September 2020 school term, the uncle and aunts who had been home-schooled started to attend schools (with the exception of one who had already been attending since October 2019).

4.20. Child I's case was closed to Early Help support mid-September 2020. The support given had included moving Mum, Dad and Child I into their home, charity applications for a new washing machine, the donation of a highchair and a referral for support to access benefits. The family were reportedly settled when the case closed and there is no record of any missed or cancelled appointments. There is no evidence within health visitor records of the health visitor service ever being aware of the Early Help support that had been provided to Child I and her parents.

4.21. This review has been unable to confirm the exact date, but has been informed that around the beginning of September 2020, Maternal Uncle 2, moved into Mum's address with her, Dad, and Child I.

4.22. Having left the home address, Child I was not subject to the Initial Child Protection Conference regarding Child I's youngest aunts and uncle. The meeting concluded that the threshold for a Child Protection Plan was not met, but Child in Need was agreed. The Child in Need plan was to address the health and education needs and also included actions to safeguard the children from the risk of sexual harm posed by

[10] A Parenting Assessment Manual Sexual Abuse Parent Profile was completed with Dad.

an older sibling (who didn't currently live with the family) who was known to pose a risk to children and was known to have had an incestuous relationship with a sister (also not currently living with the family).

4.23. After four months it was a unanimous decision of all the professionals present at the aunts and uncle's Child In Need meeting that the plan be discontinued due to the progress made by the family. However, a few weeks after, a special school nurse raised concerns in supervision that she felt this was the wrong decision. The special school nurse had been present at the Child in Need meeting and had not raised concerns. Since the meeting she had reflected upon the decision to close Child in Need and she now spoke of a 'gut feeling' which, whilst it made her feel uneasy about the situation, she didn't know how to progress. She was concerned that not all the issues had been resolved. She was advised to contact the social worker for discussion prior to the official closure of the Child in Need and to highlight the areas of concern. However, the decision to close had already been conveyed to the family and the case had been closed. Consequently, a new referral to Children's Social Care would have been required outlining the concerns. Given that there were no new concerns to report, the special school nurse doubted that the threshold would be reached. (Thresholds are discussed later in this report.)

4.24. At the beginning of June 2021, a Strengthening Families Practitioner health visitor contacted Children's Social Care to advise that Mum had commenced weaning early and had not taken Child I for her immunisations. There does not appear to have been any response from Children's Social Care to the Strengthening Families Practitioner.

4.25. In June 2021 Staffordshire Police SafeNet Team received intelligence regarding Maternal Uncle 2 and Indecent Images.

4.26. In August 2021 a health visitor attended Mum's address to undertake Child I's 12-month review which was already overdue. The health visitor was told by Dad that Child I was at MGF's address with Mum and that he and Mum had separated although they were still residing together. A few weeks later Dad reported to his doctor that his depression had worsened. An urgent referral was made to the mental health access team. (There is no evidence of the doctor recognising any potential risk to Child I as a young baby around this time.) Community Mental Health Services struggled to contact Dad at first but when they did make contact, Dad disclosed his feelings and self-harming/suicidal thoughts. He disclosed how he was currently sleeping on Child I's Mum's sofa, but that their relationship had broken down.

4.27. The aforementioned information received by Staffordshire Police in June 2021 resulted in Maternal Uncle 2 (aged 31 years at this time) being arrested in September 2021. At this time Maternal Uncle 2 said he had been living with Child I's Mum and Dad, and Child I for four months (this contradicts other information provided to this review which suggested he had moved in September 2020). Maternal Uncle 2 was interviewed, and items were seized for examination.

4.28. Maternal Uncle 2 was then bailed with conditions which prevented him having any contact at any time with anyone under the age of 18, whilst the investigation continued. Children's Social Care commenced Children's Social Work Assessments for Child I and the younger aunts and uncles who were potentially at risk (referred by police).

4.29. Maternal Uncle 2 initially went to stay with a brother, but Mum and Child I later went to stay at MGF's address and Maternal Uncle 2 moved back into Child I's Mum's address with her Dad.

4.30. In September 2021 a full mental health self-assessment was undertaken with Dad by Community Mental Health Services (on the telephone due to Covid) during which he disclosed the abuse from his stepfather and the fact he had been in care. Following this assessment, the Community Mental Health Service's attempts to contact Dad proved futile. (He was subsequently discharged from the service on the 30th of March 2022.)

4.31. On the 27th of October 2021 Child I was closed to the Local Authority following completion of the assessment which found Mum and Dad were appropriately safeguarding her.

4.32. It was during this period of professional intervention (September 2021) that MGM was diagnosed with a terminal illness.

4.33. After not being presented to the health visitor for her 12-month health review, Child I was still not taken to any subsequent arranged appointments until she was 20 months old (in October 2021). Interestingly it is documented that a maternal uncle was present for this visit, but he is not named. On this visit, Mum reported to the health visitor that Child I was humping the floor when tired. The health visitor explained this to be normal development and reassured Mum.

4.34. On the 3rd of November 2021, one of Child I's aunts aged 16 at the time, reported that MGF had hit her. The aunt also disclosed that a brother and sister had sex when the family had resided in the South West. When asked more about this, the aunt said that the brother was now in prison. No names were provided to confirm which siblings she was referring to. The aunt was placed in Short Breaks overnight by the Emergency Duty Service but returned home to parents the following day. Support via the Early Help Team was offered but the family declined. (In March 2022 the relationship between this aunt and MGF further broke down and she was placed in supported accommodation.)

4.35. On the 13th of December 2021 police changed Maternal Uncle 2's bail conditions and he became subject to 'Release under Investigation'. Bail is reviewed at different milestones due to the impact of conditions placed upon individuals on their daily life. The decision to remove Maternal Uncle 2's conditions and place him on 'Released under Investigation' was made after police had been assured by the social worker that an agreed social care safety plan was in place. The risk to other children was considered but it was decided that it was not specific enough to warrant further extensions of the bail conditions.

4.36. On the 14th of December 2021 Mum booked antenatal care for a second pregnancy at eight weeks gestation.

4.37. At the beginning of May 2022, Dad reported to the police that Mum had pushed him during an argument and smashed a mirror. He did not support any police investigation. Mum left the address with Child I, stating she would stay away for a few days.

4.38. Following further missed appointments, the health visitor undertook Child I's 2-year developmental review at Mum's home address on the 17th of June 2022. There were no concerns for Child I's development, but Mum raised concerns that Child I was grinding the floor when upset. Advice was given to Mum to manage the behaviour.

4.39. On the 20th of June 2022, following examination of Maternal Uncle 2's mobile phone, a second male suspect was identified in another force area. This second suspect was arrested and during interview admitted that he had directed Maternal Uncle 2 to abuse a child. The child was later identified to be Child I (confirmed to have been one year old at the time). Consequently, police arrested Maternal Uncle 2 for rape of a child under 13; making, possessing, and distributing indecent images of children; and possession of extreme pornography (and possession of cannabis). Maternal Uncle 2 was interviewed and following admissions he was further arrested for sexual assault by touching of a child under 13 and attempting to arrange/facilitate the commission of a child sex offence.

4.40. The police referred Child I to Children's Social Care. Mum and Dad confirmed that Child I had not been unsupervised in the care of Maternal Uncle 2 since his arrest in 2021.

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 evidences 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[11], *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*

5.3. 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.

[11] Trauma Memory - The Child Psychology Service

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. There is a history of sexual abuse and sexualised behaviours within Child I's wider family as evidenced by the information held by previous local authorities which 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 (PPRC), and
- There had been multiple disclosures of sexualised behaviours between many of the aunts and uncles.

This information became known to Staffordshire Children's Social Care in April 2020. It was included within the assessment content and was later shared multi-agency at the aunts and uncle's Child Protection Conference in September 2020.

6.2. It also became known to Children's Social Care in April 2020, that PGM had historically been concerned about Dad displaying sexual behaviour against his much younger sister. And that PGM had reported that Dad had witnessed her being raped by his father on multiple occasions as a child. This information was not immediately shared with all of the professionals working around Child I and her parents, but later became known to the Community Mental Health Team when they were assessing Dad around August/September 2021.

6.3. Intra-familial[12] patterns of sexual abuse such as these disclosed within Mum's and Dad's wider family 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. This needed to be understood when the sexual behaviour became known to professionals in Staffordshire who were working with Child I and her wider family.

6.4. 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. Much child sexual abuse within a family, for many reasons[13], is not spoken of. It is believed such abuse may take place for many years and is rarely a one-off incident.

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

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

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

affected? Instead, this review has been informed that professionals in Staffordshire formed a presumption that the sexual behaviours disclosed within Mum's wider family had been addressed by the professionals in 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 shared by the previous authorities, 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 respond differently - many will be traumatised. Significant adults around them can help them recover – those adults often being teachers.

6.8. The professionals in Staffordshire 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. The information provided by the previous local authorities was fed into the child protection conference that convened regarding Child I's aunts and uncle in September 2020. Professionals have reflected however that neither the conference reports nor the conference discussions evaluated the sexual behaviour. Further professional discussion established that the sexual behaviour was missed because the conference focussed predominantly upon the neglect of the children. Though, the Conference Chair did note the sexual risk in relation to an older uncle (who was reported to be a known risk to children) and set appropriate safety actions. These included direct work with the aunts and uncle, but there is no evidence of this work having been completed.

6.10. Child I was not subject to this conference and consequently the meeting did not consider any risk to Child I. This is discussed later in the report.

6.11. Following from the information being provided by the other local authorities, in November 2021 one of Child I's aunts further referenced the historic sexualised sibling behaviours during a conversation in her school. The school emailed Children's Social Care to inform of the conversation and Children's Social Care responded with confirmation of the aunt currently having a support worker and confirming that the *family had a concerning history in regard to sexual offences*. The school was requested to continue to share any allegations.

6.12. This was an opportunity to open up discussion with the aunt. But when she was approached by her support worker, the aunt no longer wanted to discuss it - which illustrates the importance of asking questions at the time an individual is feeling able to disclose. Such windows of opportunity must be maximised.

6.13. This disclosure in school could have potentially been indicative of a growing awareness regarding the appropriateness of behaviours within the aunt's household. The aunt had only started school in September 2020, having been previously home schooled, and in the absence of a school environment, some children do not have the sources of healthy relationships to compare to their own. Learning of friend's lives helps them to recognise that their own 'normal' is not the 'norm'. Sadly, this review has been unable to engage with any family members to gain insight into their thoughts and actions but there is interesting discussion[14] on the website 'The Mighty' (where people share their lived experiences) which helps one gain an understanding as to how and why children may not recognise abuse in their family.

6.14. The school disclosure highlights the influence an education provider can have (through social interaction and relationship education) which can help children to understand their home environment. This evidences the importance of schools having good sexual/relationship education and a robust response to all student disclosures. A standing that is strengthened by the Centre of Expertise on Child Sexual Abuse[15], who report that harmful sexual behaviour/abuse involving child siblings is thought to be the most common form of intra-familial child sexual abuse and is an issue that most protection practitioners will encounter at some stage.

6.15. The schools involved with this review have informed of comprehensive 'Personal, Social, Health and Economic' curriculums and safeguarding policies being in place. But one of the schools mentioned challenges when attempting to contact Children's Social Care with concerns, in terms of initially gaining consent from parents to share information sometimes being challenging.

6.16. Over recent years there has been recognition of how some individuals might not want professional involvement. This recognition has resulted in the development of strengths-based practice models such as Signs of Safety. But still, such practice models are often reliant upon parents' agreement to work with professionals in the first place. A previously published Practice Review[16] (in a different geographical area) has highlighted how a parent can feel apprehensive of professional involvement based upon negative experiences. This is understandable, and professional shouldn't ever underestimate the impact they can have on a family when they go into a person's home and start to ask questions.

6.17. Professionals who are attempting to gain consent from parents have a role to play in diminishing hostility towards professional bodies and in helping members of the community to work through resistance. Individuals need to be supported, encouraged to see the value of professional support, and reassured that professionals want to help bring about improvement. Professionals' discussions around how to do this

[14] 13 Reasons People Didn't Realize They Were Being Abused as Kids Until Adulthood (themighty.com)
[15] Home | CSA Centre
[16] NSPCC library catalogue

highlighted that leaflets[17] exist in Staffordshire to support professionals. Schools were unaware of these, and the Children's Social Care Manager assured the review that she would feed this back for reflection.

6.18. Even when not easily gained, consent should not be given up on - particularly because it is important to ensure that any individual disclosing problematic sexual behaviours (historic or current) is supported.

6.19. The long-term effects of trauma such as that triggered by sexual abuse, can cause a multitude of challenges for which an individual will develop avoidance and coping mechanisms. Effectively addressing sexual abuse can reduce this risk of further severe damage.

6.20. Sexual abuse is known to be linked to many mental health disorders such as depression and anxiety and if not dealt with effectively, the effects can be prolonged into adulthood – resulting in irreversible damage. The mental health issues self-reported by Mum cannot be overlooked here. Although this report recognises that her mental health is not necessarily indicative of any abuse in her own childhood, given the family history, best practice would have kept an open mind and provided further professional curiosity. The signs of sexual abuse in adult survivors can be subtle and thus overlooked, but counselling with a professional sexual abuse therapist is crucial for those who have experienced sexual abuse.

6.21. Service response was discussed in the learning events and professionals' frustrations regarding a shortage of specialist sexual abuse workers was clear. They debated how there were no longer NSPCC[18] services in the area and no resources to fund other work. Social workers explained how they are trained in communicating with children but have no specialised training regarding talking to children about sexualised behaviours. And professionals did not feel qualified to deliver specialist services.

6.22. Panel members noted how in addition to the NSPCC other local provisions are available:

- The Sexual Abuse Rape Advice Centre[19] 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[20] 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[21] 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[22] provide free counselling and support services for anyone from the age of 4 who has been affected by sexual violence and abuse.

[17] https://www.staffsscb.org.uk/working-together-to-safeguard-children/publications/
[18] National Society for Prevention of Cruelty to Children.
[19] SARAC: Sexual & Domestic Abuse & Rape Advice Centre | The Survivors Trust
[20] Grange Park - Supporting the victims of Rape or Serious Sexual Assault
[21] Sexual Violence and Abuse - Staffordshire Women's Aid (staffordshirewomensaid.org)
[22] Savana

6.23. 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.

6.24. 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.

6.25. This review has also been informed of a new multi-agency strategy[23] '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.

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?

6.26. This review recognises that staff turnover is a factor for all agencies/organisations and can affect some professionals not having partaken in available training, including information sessions detailing local process and support. As a good starting point, particularly for new staff members, the Centre of Expertise on Child Sexual Abuse has created and launched a short, introductory eLearning[24]. The learning is designed to help those in social work, policing, education, healthcare and beyond, to understand what intra-familial child sexual abuse is, provide guidance on how to identify concerns and build knowledge and confidence in how to respond to support both children and their wider family. The course is designed for professionals at all stages of their career. It is free and takes just 90 minutes to complete the three modules.

6.27. Regardless of specialised training, fundamental practice around intra-familial abuse must include good application of information sharing, assessment of safeguarding concerns, professional curiosity, and consideration of Adverse Childhood Experiences. (Further considered later within the report.) This will assist professionals to not only identify individuals at risk of abuse but will also assist identification of potential offenders. Which as previously mentioned is important because sexual abuse can become a cycle in which

[23] Preventing-and-Responding-to-Problematic-and-Harmful-Sexual-Behaviour-Strategy-2022.pdf (staffordshire-pfcc.gov.uk)
[24] Take the eLearning course

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.

6.28. Inter-generational sexual abuse refers to abusive behaviours that are passed from an abused survivor to their descendants. It can also be referred to as transgenerational or multigenerational abuse. A study published in 2016[25], *Sexual Abuse Within the Family, The Intergenerational Transmission of Victimhood and Offending*, provides an overview of research carried out on 185 juvenile male sex offenders who received treatment in a residential centre. The study looked at their and their parents' history of sexual abuse. Its findings mostly support a social learning theory of sexual abuse. Juvenile sex offenders either from families where intra-familial abuse had occurred or whose father had a history of sexual abuse occurring during their childhood, had an increased risk of abusing children, rather than peers. Juvenile sex offenders who themselves had experienced intra-familial abuse, or who had a sibling that had suffered intra-familial abuse, had an increased risk of committing intra-familial sexual abuse.

6.29. Individuals with Sexually Problematic Behaviours are often persecuted by the public, but professionals must put any personal opinion 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.

6.30. Maternal Uncle 2 was a very much 'hidden' family member and professionals did not know enough about him to identify the 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.

6.31. 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.

6.32. Though we would like to see offenders of sexual abuse facing up to their behaviour and taking responsibility for their actions, denial is not unusual and according to Jackie Craissati[26], (a specialist with a national reputation for work with high risk and complex individuals with sexual convictions) is not linked with a greater risk of offending.

6.33. 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.

[25] Sexual Abuse Within the Family: The Intergenerational Transmission of Victimhood and Offending | SpringerLink

[26] Craissati, J. (2015). Should we worry about sex offenders who deny their offences? *Probation Journal: The Journal of Community and Criminal Justice*, 1-11

6.34. 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. Such individuals need to know that help does exist, that they can learn to manage their thoughts and they need to be encouraged to seek that help.

6.35. Individuals in the Staffordshire area must be openly spoken to by professionals and must be encouraged, in the absence of anything like the Corbett Centre being available in the local area, to seek support from the Lucy Faithfull Foundation. Individuals need to know that help is accessible before they offend. Too often help is not signposted until they have offended and been arrested. 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 visible. The Lucy Faithfull Foundation has assured this review that they are encouraging of their information about their helpline and other services to be widely shared and this can be done using their posters, and leaflets.

6.36. The Lucy Faithfull Foundation provides information and support for people troubled by their sexual thoughts about children and young people. Their website[27] 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.

6.37. The Lucy Faithfull Foundation has developed deterrence campaigns to show the serious consequences of looking at child sexual abuse images online. The video 'The Knock' features several men who are frightened of a sound that could be a "knock." In the final section, one of the men receives a knock on the door from the police. He is subsequently arrested for looking at sexual images of children online. The video ends with a message signposting potential offenders to self-help resources online and the helpline.

6.38. Lucy Faithful are happy for the videos to be used in public - they can be found at https://www.youtube.com/@stopitnowukireland/videos, posters and leaflets can be found at https://www.stopitnow.org.uk/resources/.

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?

6.39. As is evidenced by the 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

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

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.

6.40. In conclusion, several local authorities had been concerned for members of Child I's wider family as they had relocated around the country. The local authorities' information was disclosed to Staffordshire Children's Social Care in April 2020 and included that Child I's MGM had experienced sexual abuse and some of Child I's aunts and uncles were known to have engaged in intra-familial sexualised behaviours. Also, Child I's father had been accused of sexually inappropriate behaviours towards his younger sister and PGM had historically reported that Dad had witnessed her being raped by his father. Nothing was known by professionals in Staffordshire of any work that had been undertaken with wider family members to support them with their behaviours/experiences. And the historic information was not widely known to the professionals who supported Child I with universal health services. The need for all professionals working with both Child I's immediate family and that of her aunts and uncle, to know of the historical information was a prerequisite to enable appropriate assessment of risk, and to ensure that Child I was being protected. But importantly, all professionals needed to have a thorough understanding of the patterns of sexual abuse and be alert to the possibilities of this type of abuse becoming a cycle in which people who are victim, abuse others, blurring the line between victim and abuser.

Professional Application of a Think Family Approach to Safeguarding Concerns

6.41. The family history, including sexualised behaviours, whilst known to professionals who had worked with the family in other areas of the country, remained unknown to professionals in Staffordshire when the family first moved back into the area in 2018. However, Children's Social Care became aware in April 2020 when they started assessments having received a referral from the Special Education Needs Support Services Assessment Planning Team.

6.42. Documentation provided to this review evidences how social workers within their consequent assessments learned that:

- Child I's wider family had moved around the country,
- There had been historic reports of Child I's aunts and uncles being left unattended,
- There had been historical reports of Child I's aunts and uncles playing in inappropriate clothes,
- There had been historic reports of Child I's aunts and uncles screaming and shouting,
- Child protection conferences had convened in previous local authorities in respect of neglect,
- Inappropriate touching had been disclosed between Child I's mother's siblings,
- Though denied, there had been a report of MGF having been seen to slap Mum's sibling on the face, and
- An older uncle was known to be a Person Posing a Risk to Children.

6.43. In addition, the assessment in respect of Child I learned of Dad having been a Looked After Child. And during the assessment, police disclosed that PGM had reported inappropriate sexual behaviour between Dad towards his 5-year-old sister in 2011, but no further action had been taken.

6.44. There is no doubt that all the information could have been shared cross border with professionals in a more effective and speedier manner.

6.45. For example, in October 2019, prior to the information being shared with Children's Social Care, one of Child I's aunts had started school. Yet the school had not become aware of any of the family history. This school has informed the review that it has its own processes in place when a young person starts their school, to obtain the past information. The school received a paper based safeguarding file from the previously known school in Yorkshire (at the end of January 2020), with the earliest document being a social work assessment from 2004. This would have been reviewed and stored within the secure filing system, to be used when and if needed.

6.46. Whilst discussing the transference of student information in schools across borders, another school informed this review that they receive information relating to students and previous placements via the Common Transfer File. However, this relies upon previous documentation being correct and inputted appropriately. The school that Child I's uncle attends reported that their information is transferred electronically or by secure postal services with a signature upon receipt. There is then a telephone conversation or face-to-face visit with the receiving/transferring designated safeguarding lead and other professionals. However, in the case of Child I's uncle, the school were unable to identify the last school he attended.

6.47. Health information is transferred across borders to GP Practices. When Child I's extended family members and parents registered with their GP Practices in Staffordshire, a member of the administration staff within the practices would have applied for each individual's previous medical notes to be transferred. When a patient is de-registered from a previous GP Practice, their records are sent or recalled to a central processing department. Many GP surgeries now have an instant transfer of electronic records, but any paper records must be posted (to the central processing department). The GP Practice of Mum and Dad has confirmed that their information is all electronic.

6.48. The information sent should allude to any previous child protection plans and neglect; knowledge of which may then prompt a GP Practice to refer concerns regarding, for example, multiple missed health appointments, to Children's Social Care sooner. However, in the case of Child I's wider family, GP registration had not been consistent, and any health records would have had gaps.

6.49. Only Mum had registered with a GP Practice prior to the information becoming known in April 2020.

6.50. Mum registered at the medical practice when she 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.

6.51. 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.*

6.52. 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.

6.53. 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.

6.54. 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.

6.55. 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.

6.56. 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.

6.57. Additionally, for reasons this review has been unable to establish, the information learned was reportedly not shared with Child I's health visitor. It was important to share information such as this to allow the professionals who were continually working to support Mum and Dad with first-time parenting, to assess any impact that either parents' history and/or wider family may have upon their parenting ability, and importantly to assess any risk to Child I.

6.58. There is an integrated care record called One Health and Care[28] which is designed to help health professionals and social care professionals share information and be more able to make safe decisions. The record information is limited but can be used as a prompt to decide whether or not to contact other professionals involved with an individual for further information. One Health and Care is relatively new and not everyone was aware of it - this review would recommend that its existence be promoted.

6.59. Following the assessments, Child I and her aunts and uncle 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 hesitant 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.

6.60. 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.

6.61. 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

[28] One Health and Care - Staffordshire County Council

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.

6.62. 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.

6.63. 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.

6.64. 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.
- 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.

6.65. 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.

6.66. 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.

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

6.68. One of the schools involved with this review has informed that to improve future practice and encourage a 'Whole Family' approach they are now changing their admission forms to include more questions about the family home, who resides there, and which school siblings attend. This will allow them to share any concerns with the siblings' schools, collaborate information, and consider safeguarding for a whole family, not just an individual child.

6.69. This review has been informed that the Think Family approach is advocated at every level within professionals' practice in the Midland Partnership Foundation Trust. There is now a family assessment on each child's electronic record which is completed at the new birth visit or a 'new to area' contact and information can be added to the record at any later visit. The family assessment provides an opportunity for professionals to ask about the immediate and wider family members, where it is deemed relevant, i.e., social, and psychological background information. At the time of Child I's birth, the family assessment form was not in use, however, even had it been, it must be recognised that there would be limitations as to what information would be shared within the form as it is part of the child's records. There should be relevant information recorded about significant family members, including those with parental responsibility, but due to data protection it would not be deemed acceptable to include in-depth information about wider family members.

6.70. Midland Partnership Foundation Trust have also advised that Think Family is evidenced within their multidisciplinary training packages, safeguarding supervisions and within other available opportunities such as child safeguarding day/week and adult safeguarding week.

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?

6.71. 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.

6.72. 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?

6.73. 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?

6.74. It is crucial that this be afforded critical consideration as the Centre of Expertise on Child Sexual Abuse annual report[29] (which brings together available data from children's social care, policing, criminal justice and health, to provide a unique insight into the changing trends in practice and picture of abuse across England and Wales) has highlighted increasing concern about the growing time it takes for reported child sexual abuse offences to proceed through the criminal justice system. In fact, in 2021/22 there was typically a wait of nearly two years (614 days) between reporting child sexual abuse to the police and the case concluding in court.

6.75. 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.

6.76. Staffordshire police upon exploring Child I's circumstances have recognised that the main area for police review involves the initial triage process that takes place when an offender is arrested. In the case of Maternal Uncle 2, the triage should have identified first generation images created by Maternal Uncle 2 but did not. The police need to understand why this was not picked up as they now recognise how it impacted upon the safeguarding actions for Child I and her younger aunts and uncle. The police have assured this review of new technology which will speed up the processes and improve identification.

6.77. The police have also updated the SafeNet[30] process to ensure quick referrals into partner agencies when children are identified as being associated to suspects. An audit of the new process has been undertaken and has identified that Officers contact and refer, where necessary, to both internal departments and external agencies. A further partner review is to be completed with Children's Social care and a further audit is to be scheduled.

6.78. However, 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.

[29] Trends in official data - CSA Centre

[30] The SafeNet Team is an integral part of the Force's Specialist Investigations, with responsibility for protecting children from harm through investigations of online Child Sexual Abuse

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?

6.79. Soon after Maternal Uncle 2's arrest in June 2022 Children's Social Care sent a Public Law Outline letter to Mum and Dad outlining their concerns as follows:

- We are worried about both of your childhood experiences and functioning in both of your respective family networks in respect to sexual behaviours and abuse.
- We are worried about the significant history of Local Authority involvement.
- We are worried that Child I has been sexually abused by Mum's brother whilst he resided in your home.
- We are worried about your ability to safeguard your daughter Child I and unborn child from the risk of future sexual abuse.

6.80. The first two concerns outlined had been known to professionals since April 2020. The third concern had been known to professionals since December 2021 and the final concern had not been deemed to be a concern previously. However, upon professionals' considering all the concerns simultaneously, Child I's circumstances were presented to the Legal Gateway Meeting and Mum and Dad were advised during a meeting that the local authority was applying for an Interim Care Order.

Safeguarding is Everyone's Business

6.81. As previously mentioned, in February 2021 a special school nurse opined reservations about Child I's aunts and uncle's Child in Need plan being stepped down. 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'.

6.82. Whilst this 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.*

6.83. 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.

6.84. 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.

6.85. Professionals need to raise their individual concerns because as is clearly stated on the local Borough Councils 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.

6.86. 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.

6.87. The Social Care Institute of Excellence[31] (SCIE) has found in an analysis of case reviews that one of the reasons for a professional not resolving a difference of opinion with Children's Social Care is that they feel unable to challenge Children's Social Care decisions as *social workers are seen as the experts*.

6.88. This review has sensed a perceived power imbalance between agencies. In addition to the special school nurse not trusting her intuition in a multi-agency meeting, one of the schools noted *not feeling listened to* by Children's Social Care when they wanted to voice concerns for a child. Clearly Children's Social Care brings important specialist safeguarding knowledge to the multi-agency arena, but this perceived imbalance of agencies must be addressed.

6.89. If left unaddressed this perceived power balance between professionals can impact upon professional challenge and professionals will be in danger of accepting when Children's Social Care say that a threshold is not met, or a case should close, without challenge. Certainly, in this case, the closure of Child in Need impacted a concerned professional confidence not to re-refer.

6.90. Professionals discussing the care and support offered to Child I and her wider family often referred to thresholds not being met. Could a better shared understanding of risk and 'threshold descriptors' help dissolve imbalance between agencies?

[31] Social Care Institute for Excellence (SCIE)

6.91. 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[32] 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. Given the perceived power imbalance, 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. The guidance supports professionals in this lead role.

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

6.93. 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.

6.94. Professional curiosity and challenge are fundamental when working to keep children safe. However, *respectful uncertainty*[33] is not easy. It can feel uncomfortable to challenge parents and can be difficult. Such practice is complex and requires skilled practitioners.

6.95. 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?

6.96. A component of professional curiosity is exploration of a person's history. Amongst the reasons this is important is identification of trauma. Many individuals who are living with trauma continue to feel unsafe,

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

[33] In his 2003 inquiry report into the death of Victoria Climbie, Lord Laming came up with the phrase "respectful uncertainty" to describe the attitude social workers need: that they must be much more sceptical and mistrustful about what might really be happening behind closed doors.

anxious and struggle to trust others. A framework practice, based upon knowledge and understanding of how trauma affects a person's life and needs is known as trauma-informed practice.

6.97. Trauma informed practice requires consideration of a person's lived experiences and of how a person's presentation may be an adaptation to their trauma rather than a personal characteristic. It requires professionals to consider and explore any Adverse Childhood Experiences an individual may have experienced.

6.98. Adverse Childhood Experiences are a set of traumatic events or circumstances occurring before the age of 18. They include all types of abuse and neglect as well as domestic violence abuse, parental mental illness, substance use, divorce, and imprisonment.

6.99. A recent Early Intervention Foundation report[34], published in January 2022, states that whilst studies show that practitioners are often quite enthusiastic about trauma-informed principles and believe that awareness of them will substantially improve their ability to engage and support individuals … studies also show that there is a notable lack of consistency in how trauma-informed principles are applied in practice, and their value to practitioners and clients is yet to be rigorously evaluated.

6.100. In line with this, this review has seen little exploration of the lived experiences of Mum and Child I's older aunts and uncles when they were children. This includes Maternal Uncle 2 who for reasons previously discussed, we know very little about.

6.101. To example the importance of trauma informed practice exploring Adverse Childhood Experiences (and because this review is considering Maternal Uncle 2's violent offence perpetrated against Child I) this review will reflect upon some research[35] undertaken by Public Health Wales, in collaboration with Bangor University. Their research explored Adverse Childhood Experiences in an offender population and found a much higher prevalence of Adverse Childhood Experiences. It concluded that multiple Adverse Childhood Experiences can increase the risk of being charged with a violent offence, serving a sentence in a young offender institute, and becoming a prolific offender.

6.102. However, another study 'Adverse Childhood Experiences in the Lives of Male Sex Offenders: Implications for Trauma-Informed Care' (which explored the prevalence of childhood trauma in a sample of male sexual offenders) found no association between Adverse Childhood Experiences and sexual offending. But it is notable that the crime types were self-reported, and it may be that the prevalence of sexual offences is an underestimation due to issues of vulnerability associated with this admission in a prison setting and/or stigma associated with this crime type.

6.103. This review would therefore ask whether trauma informed practice and exploration of Adverse Childhood Experiences undertaken historically with Maternal Uncle 2, may have benefitted him and consequently, the wider family. It would also note that the above research highlights the importance that

[34] trauma-informed-approaches-within-childrens-social-care.pdf
[35] https://phw.nhs.wales/files/aces/the-prisoner-ace-survey/

work be undertaken now with the younger members of Child I's wider family before their childhood events potentially have a detrimental impact upon their future actions.

6.104. In 2018 a small group of front-line practitioners with extensive experience of supporting children living with trauma and/or experiencing traumatic events wrote 'The Little Book of Adverse Childhood Experiences[36]'. The book informs other practitioners about what Adverse Childhood Experiences are, what their immediate effects are and how they can affect children both in the short-term and throughout their lives. It offers case study examples, and also discusses a number of different ways that have been developed to manage the effects of Adverse Childhood Experiences and to prevent them occurring in the first place. It is a good starting place for any professional wishing to learn more.

6.105. No national strategy has been adopted in England to implement an Adverse Childhood Experience Framework and individual local authorities have been left to develop their own individual screening programmes in an effort to provide early intervention.

6.106. Staffordshire Safeguarding Children Board informed this review that Adverse Childhood Experience training was introduced in April 2022. There have been four courses to date with a further course currently planned. Over the four completed courses there were 250 places available. 116 were booked but only 110 attended. There was a learning gain of 1.26 in knowledge and 1.38 in confidence overall with the majority of attendees scoring 4 and above on the evaluation. This learning gain was calculated based on a scoring answer from 1 to 6 with 6 being the highest. The questions were asked pre course and then again post course. Post course evaluation also posed the question - *How will you transfer the knowledge and skills into your everyday practice at work? Please describe?* Examples of responses are - *I will be curious in exploring what Adverse Childhood Experience 's a child may have experienced and use this knowledge to champion the child and support resilience building,* and *This course has given me the knowledge to be more aware and more understanding of Adverse Childhood Experience's and the effect they have not only on the child but their family too, what to look out for and what support can be given. A* 3-month evaluation of the course asked - *As a result of the training give examples of how you have improved lives of children, young people, and their families (without using names)?* Responses included: *I have a young person who hoards things and I now understand that this isn't just laziness it is an effect from her childhood.*

6.107. The Board is also promoting a free eLearning course 'Introduction to Adverse Childhood Experiences' on its Learning zone.

6.108. With regards to trauma-informed practice, Staffordshire County Council have been promoting the approach since 2019 with 5 cohorts of 2-day training. These courses have all been fully subscribed. And a one-off taster course; Trauma and Change is to be offered in April 2023.

6.109. Education professionals in Staffordshire has been implementing and facilitating specific training since the academic year 2018-19, including courses delivered by Dr Dawn Bradley on 'Attachment, trauma and education', and 'Emotion Coaching' delivered by staff from Emotion Coaching UK. Alongside this, the Virtual School has been promoting and providing support for schools to become attachment and trauma informed,

[36] Little_Book_of_ACEs_Final-2.pdf

with all schools invited to attend a trauma and attachment conference in June 2022. This goes alongside the work on school relational and restorative standards approach, and a recent opportunity for school staff to apply for a fully funded postgraduate 20 credit option entitled 'Attachment, Trauma & Mental Health Professional Development Training and Practitioner Enquiry', via Chester University.

6.110. In addition, there are guides, videos, and resources available for education staff on the Staffordshire Learning Net for school.

6.111. Staffordshire police have training day events to support the force on the subject of Trauma Informed Training. An external provider – Daddyless Daughters[37] has delivered a very successful and well received session, consequently the force has invested in the rollout of additional sessions to support the frontline.

6.112. As stated, professional curiosity is key to helping identify Adverse Childhood Experiences and trauma. Professional curiosity application was discussed with frontline staff at the learning events and concerns were raised regarding:

- time restraints,
- professional's not wanting to present as 'nosey', and
- the risk of damaging relationships with individuals.

But Safeguarding is Everyone's Business and therefore all professionals need to employ professional curiosity throughout their practice. They must remain curious, seek clarity around a situation if needs be, and proactively look for any safeguarding concerns. Nothing should be taken at face value.

6.113. Time restraints, as mentioned by the professionals involved with this review, are a valid concern for all. With regards to social workers, it is one that is echoed by the government who has pledged action to tackle "excessive" workload pressures on council children's social workers as part of its response to the Independent Review of Children's Social Care[38]. However, resource pressures must not be allowed to wring out the fundamental necessaries of safeguarding practice, and the need to be professionally curious cannot be compromised.

6.114. 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. Were enough questions asked around both Mum's and Dad's understanding of potential risks Maternal Uncle 2 could pose. Were questions asked of Mum and Dad to reassure professionals that both parents understood what the images constituted? Were enough questions asked around parents' understanding of 'supervised'?

6.115. The health visitor has questioned whether she could have shown more professional curiosity when Mum told her of Child I dry humping the floor. The health visitor advised parents that such behaviour can be

[37] HOME | Daddyless Daughters
[38] The-independent-review-of-childrens-social-care-Final-report.pdf (childrenssocialcare.independent-review.uk)

normal as it can be a comforting motion, and to distract with a different comforter – however, she recalled that at the time, she was unaware of the concerns regarding sexualised behaviour in the wider family, and whilst humping isn't commonly a sign of sexual abuse, she wondered whether she might have considered different advice had she have known. She concluded that in future she would ask more questions and consider reporting any concerns that consequently arise.

6.116. 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 curious and view individuals through a wide lens that doesn't focus wholly upon the task concerned.

6.117. 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.

6.118. 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.

6.119. In December 2019 a coronavirus emerged which was rapidly identified as pandemic. As a result, the United Kingdom saw the Prime Minister announcing a national lockdown on the 23rd of March 2020. Initially during this period, all "non-essential" high street businesses were closed, and people were ordered to stay at home (permitted to leave for essential purposes only, such as buying food or for medical reasons).

6.120. Starting in May 2020, the laws were slowly relaxed, and most lockdown restrictions were lifted on the 4th of July 2020. However, to contain the virus, there soon followed across England, months of local restrictions which developed into a "four tier system", and at times effected further closure of non-essential retail and hospitality, and personal restrictions of movement.

6.121. On the 6th of January 2021, a rising number of coronavirus cases saw national restrictions being reintroduced. It wasn't until the 8th of March 2021, that England began a phased exit with a plan, known as the 'roadmap' out of lockdown. This was intended to *'cautiously but irreversibly'* ease lockdown restrictions. England moved through the roadmap as planned but step four was delayed until the 19th of July 2021 to allow more people to receive their first dose of a coronavirus vaccine.

6.122. 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.

6.123. 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.

6.124. 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.

6.125. 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.

6.126. 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.

6.127. 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.

6.128. 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 Children 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. 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[39] and Alex[40], 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.

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

[39] Published Child Safeguarding Practice Reviews - Staffordshire Safeguarding Children Board (staffsscb.org.uk)
[40] Not yet published.

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?