Adam & Anna

Serious Case Review into
Intra-familial Sexual Abuse

for Southampton Local Children
Safeguarding Board

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1 Introduction, Terms of Reference and methodology

1.1 In November 2017, in accordance with regulation 5(1)(e) Local Safeguarding Children Boards Regulations 2006, the LSCB determined to undertake a serious case review after notification that the children known within this review as 'Adam' and 'Anna' had suffered intra-familial sexual abuse during a period of time that they were subject to child protection planning. The conviction of their Paternal Uncle ['PU'] in July 2017 for multiple counts of abuse perpetrated against Adam and Anna established that both had suffered intra-familial child sexual abuse ['IFCSA']. This is defined as '*sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member or someone otherwise linked to the family context or environment, whether or not they are a family member. Within this definition, perpetrators may be close to the victim (e.g. father, uncle, stepfather) or less familiar (e.g. family friend, babysitter).*'[1] PU's convictions related to sexual abuse which took place across a period from around December 2015 until his arrest. The abuse took place both within the family home and at the PU's home where, until December 2016 the children had also lived.

1.2 In July 2017, the Local Authority commenced proceedings under s31 Children Act 1989 which culminated in the children being removed from their parent's care and placed apart from each-other into long-term arrangements. The Children's Guardian reported concerns to the Court that there had been missed opportunities to initiate care proceedings earlier, prompting her to refer this case to the LSCB for consideration of a serious case review.[2]

1.3 The purpose of this review is to understand the barriers to safeguarding 'Adam' and 'Anna' from intra-familial sexual abuse and to better understand the correlation between neglect and intra-familial sexual abuse. The review will explore how effectively agencies worked together to identify and address the risk posed to the children, what the barriers were and what can be learned from this to improve future professional practice. The period under review is from October 2013, when fresh concerns regarding neglect of the children were raised, to July 2017 when the children were received into the Local Authority's care.

1.4 **The review is not intended to explore the role of the family in preventing the abuse or their capacity to protect the children. Those issues were explored by the Family Court, in which both parents were represented and findings of this review are not intended to duplicate that process or any findings of fact made by the Court; that is strictly outside the scope of this review. Nor is it intended to dilute or deflect culpability for the harm caused to Adam and Anna from both the neglect and intra-familial sexual abuse they have suffered. The purpose of any serious case review is not to replicate civil or criminal processes or to apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately to improve the safeguarding and wellbeing of children in the future.**

1.5 Southampton City Council's Children Social Care department [hereafter referred to as 'CSC'] had been involved with the extended family since 1985 and specifically with Adam from 2009, when concerns regarding the inappropriate living conditions prompted a decision to support Adam through a Child Protection Plan under the category of Neglect. At that time, CSC were informed of family members relevant offending history. In particular, it was reported that the paternal grandfather [hereafter referred to as 'PGF'] had been charged in 2003 with indecent assault, gross indecency and attempted rape against his step daughter whilst she was between the ages of 8.5-15. This had not resulted in a conviction. He did,

[1] Children's Commissioner, Report to the Inquiry into Sexual Abuse 2015, p6
[2] CAFCASS Case Analysis report, dated 16.08.17

however, have convictions for indecent exposure (1982) and battery (2003). In addition, the paternal uncle ['PU'] (who lived within the family home) had previously been accused of sexual assault (when aged 13) against a 6-year-old nephew. This was investigated by the police at the time, but a decision made that there was insufficient evidence to progress a criminal prosecution.

1.6 The children's father also had convictions for battery (2006), intimidating a witness (2004), possession of a bladed article (2002) and shoplifting (2001). Practitioners reported F had made threats to kill social workers involved in the case during 2009, including on one occasion (in July 2009) which required Police attendance at CSC offices. It was reported that F repeatedly refused to allow social care staff into the family home. It was also disclosed that F had claimed to have been dismissed from the army following an incident where he had put a gun in his commanding officers mouth and threatened to kill him. It was acknowledged that this had not been verified.

1.7 The case was stepped down in 2010 to a Child in Need plan. Despite information received from the health visitor in May 2010 that Adam and his mother's personal hygiene had 'dipped' and reports in August that he had numerous flea bites to his arms and legs, the case was subsequently closed in August 2010. It was noted that '*progress has been made by the family to improve home conditions, however it is felt that this is still not up to standards*.'[3] The closure summary concluded there was no role for CSC as the health visitor and support worker would monitor the situation until May 2011. There does not appear to be any corresponding request to the health visitor service to maintain contact or re-refer if concerns continue.

1.8 Previous Serious Case Reviews published in May 2014 by Southampton's LSCB had identified system wide issues [detailed within in pg4.1-4.4 of this report] that may also have been a factor in the poor assessment and inadequate support offered Adam during that period. This review does not intend to duplicate those investigations or evaluate the impact of those reports; this is work already undertaken by the LSCB and reported in their Annual Reports. Although it preceded the period under review, the LSCB has requested this review consider whether there was anything more to learn specific to the facts of this case for that period.

1.9 As the focus of this review is to evaluate inter-agency practice in response to risk of intra-familial sexual abuse, it is important to highlight from the outset that the enquiries have focused on this issue, rather than seek to ascertain the extent or impact on the children of the neglect they suffered. This is not to minimize the level and persistent nature of the neglect they suffered or the impact that this form of maltreatment had on either Adam or Anna.

1.10 For most of the period under review, the children lived with their mother [hereafter referred to as 'M] and father [hereafter referred to as 'F'] within their paternal grandfather's home. Their paternal uncle also resided at this address. F was the main carer for the children and reported to suffer with vertigo, brought on by stress. M worked part-time; her extended family lived abroad. Both parents were frequently reported to have minimised professional concerns, not engaged honestly or responded positively to professional advice. The PGF reported mobility and mental health difficulties and referred to the PU as his carer. It was reported in 2014 that, despite his disabilities, he was left in sole care of the children 'a lot'.

1.11 Conditions in the home were described as an '*unclean and unsafe home environment.* [The children] *are at risk of serious health issues due to unhygienic state of the*

[3] Taken from the Chronology submitted to the Family Court as part of the s31 proceedings

home environment'.[4] For example, concerns were recorded that the kitchen was cluttered, with sticky floors and the cooker posed a fire risk due to build up of grease and dirt. The toilet facilities were reported to be 'extremely poor' and the children's bedrooms dirty, with bedding unwashed for 'some while'. The main living areas were cluttered, leaving little space for the children to play and the garden was littered with rotten carpet and dangerous items, including a burnt out spring mattress. Staff raised concerns that Adam attended school in soiled clothes and '*almost always observed as being dirty*.'[5]

1.12 The long-term impact for both children of the neglect is documented within this report, because it has formed their understanding of the world and will impact on their resilience and ability to recover as they grow into adulthood. It is clear, from practitioners who have worked to support their recovery, that anyone caring for them and practitioners supporting their educational, emotional and psychological development will need to fully understand and appreciate how significant the neglect was and how their current behaviour and future presentation may continue to be affected by those early experiences.

1.13 It is also relevant to explain that, even now, there is very little research into the relationship between neglect and adult perpetrated intra-familial sexual abuse. In 2016 the NSPCC and Action for Children with Research in Practice published a report[6] exploring the relationship between neglect and intra-familial child sexual abuse. Whilst it is accepted that not all children experience multiple forms of harm, that paper draws attention to the importance for researchers and, by extension, practitioners in understanding the full victimisation profiles of children at risk of poly-victimisation in order to address the cumulative impacts of harm and to find ways of supporting families to ensure that perpetrators find fewer opportunities to target and abuse children. It does, however, recognise current literature is '*in the early phases of describing the factors that may explain these complex experiences.*'[7]

1.14 This review has drawn on primary case materials and summary information provided by the agencies involved and the policy and guidance documents used to evaluate practice in this area set out in appendix 1. The agencies involved in this case provided a chronology of their contact with the family over the period under review. The agencies, alongside the SCR panel members (who are senior representatives from LSCB partner organisations) provided supplementary information to address the key lines of enquiry. The review also benefitted from input by practitioners directly involved in decision making throughout the period of review. The author is grateful to staff who contributed by providing their views of the case as this helped to analyse key events; providing clarity on what affected practitioner's actions and decision making at the time. This information has shaped the narrative below and provided valuable insight so that this review is based on a systems approach to overcoming barriers to effective multi-agency safeguarding practice.

1.15 The review has been asked to consider:

- Was adequate consideration given by practitioners to the risk of sexual abuse, given disclosure of past concerns regarding intra-familial sexual abuse?
- Was the 'voice of the child' given sufficient weight by all services and appropriately responded to for referral/ escalation?
- Were the Child Protection Conference and Public Law Outline processes correctly followed and used effectively, if not, what were the barriers?

[4] Therapeutic needs assessment, BRS service, dated 12.12.17
[5] ICPC minutes, dated 09.09.14
[6] By Debra Allnock, available at: https://www.nspcc.org.uk/globalassets/documents/research-reports/neglect-intrafamilial-child-sexual-abuse-evidence-scope-2.pdf
[7] Ibid, p2

- Were risk assessments informed by further disclosures and non-adherence to the protection plan?
- Was the voice of the child given sufficient weight within the child protection process?

2. Family involvement in the review

2.1 Letters were sent to Adam and Anna's parents notifying them that the LSCB would be undertaking a review of the case, setting out the purpose and scope of the review and inviting them make contact if they wished to contribute or discuss the findings. A subsequent letter was sent when the review was reaching conclusions to request that they make contact if they wished to discuss the findings or input into the review. No reply was received and therefore they have not contributed to this review.

2.2 Careful consideration was given about how to best secure Adam and Anna's voice within the review. The children were not asked to directly contribute to the review because of their age, level of understanding, but more importantly because of the trauma that they have had to endure and the need to ensure that they have the best opportunity to develop strong bonds within their new family placements and therapeutic support networks to help them come to terms with the harm caused to them. However, the reviewer was able to meet with practitioners who had been involved in supporting the psychological recovery of the children. The reviewer is grateful for the opportunity to discuss with them the purpose and scope of the review. The reviewer was also able to take advice on how best to ensure that the review's findings and recommendations reflects the ongoing needs of the children's recovery.

3. The children

3.1 Adam is, at the time of this report an eight-year-old boy. Like his younger sister, much of his early childhood has been categorized as one of extreme neglect. In addition, until he was 6.5 years old, he shared his family home with what was later confirmed to be the perpetrator of the sexual abuse. He is described by practitioners who supported his recovery as '*an overly sad child who is desperate for acceptance, anxious, frightened and uneasy in himself… He has a sense of loneliness*.' This presentation could, they feel, be characterized as that of a deeply traumatized child and they reported that he remained terrified throughout their involvement about what he could and couldn't say.[8]

3.2 The impact on his emotional and behavioural development of living in a threatening, chaotic and potentially dangerous environment is reported by those who later supported his recovery as '*likely to have given him the perception that the world was an unsafe place, others were not there to look after and care for* [him] *well and that as an individual he was not worthy of comfort and love. Much of his energy will have gone onto basic survival in the neglectful environment in which he lived, rather than normal emotional development*'[9] The sexual abuse and early experiences of neglect have undoubtedly traumatized him. He has told practitioners that he experiences regular nightmares which disturb his sleep and acknowledged that he does not call out for support. Therapists involved in his care reported a very poor relationship between Adam and his mother; she spent little time with him and had no empathy towards him. They also reported it is likely that his early experiences within the family home means he is not used to the idea that adults will help or offer comfort and that he has therefore managed his fear at night alone.

3.3 Despite this, school was a positive, protective factor to Adam. It is a testament to his inner resilience and core optimism that he was able to do well academically. He is described

[8] Confirmed by practitioners involved in providing therapeutic support during discussions with the author of this review
[9] Therapeutic needs assessment, BRS service, dated 12.12.17

by his teachers as a likable child, with a lovely smile and a warm greeting for those he had learnt to trust. By December 2017 he was reportedly initiating contact with peers and engaged in play with them. He volunteered answers in lessons and made offers to help teachers in class. School staff noted that he appeared more independent, confident. Adam also engaged well with play therapy sessions; his therapist reported that had a sense of resilience, he had understandably found therapy very challenging and had been taken to very difficult places, but had tolerated this and built relationships and showed he could trust an adult, even though his model of relationships was so damaged. His therapists reported, he demonstrated a strong attachment to his sister, understandable given their experience of harm and his wish to offer some level of protection caused by the maltreatment they both suffered. He is likely to continue to require specialist support throughout his life to come to terms with and address the harm caused by his earliest experiences, but responds well to people who listen to him and was described by his social worker as having a genuine smile and loves to make up games. He also loves to play with Lego and play the computer game 'Minecraft'. He loves positive attention from adults. His therapist reported he was '*a pleasure to work with; he became more relaxed and confident, began finding fun and creative ways of connecting*.'

3.4 Anna is now 4 years old, her therapist described her as a smiley little girl, bouncy and endearing. Her size, presentation and speech is considerably below her chronological age and she presented as disinhibited, but could also become selectively mute with unfamiliar people. She showed an attachment to her brother; his presence offered her reassurance during play therapy sessions. Though their relationship had, naturally, been affected by their early experiences such that they did not play together and found it difficult to recognise and respond to the other's needs. Anna also exhibited clear signs of the trauma she had suffered, including nightmares which during her early recovery was associated with Adam. It was for these reasons it was concluded it was necessary to find separate placements in order to meet their welfare needs. Both children will feel the loss of each other in their lives, but it is hoped that this will afford them both an opportunity to recovery and, in time, reestablish their sibling relationship. During the course of her therapy she tried very hard to understand what was being asked of her and, week by week started to relax, entering into play and gaining greater mastery of language. Again, it is a testament to her strength and resilience that she exhibited pleasure at her new clothes and enjoyment at regaining her childhood.

4. Case Narrative and findings

Pre review practice, related to previous SCR's commissioned by Southampton's LSCB

4.1 Previous serious case reviews published by the LSCB in 2014 identified significant concerns across services during 2009-10 which impeded effective multi-agency safeguarding practice. Similar concerns appear to have impacted on decision making within this case during that period. For example, there are parallels between the recognition of risk to Child M[10] but failure to use child protection processes to plan for effective interventions, proactively search for evidence of sexual abuse, provide preventative guidance to parents/ other practitioners or the child on what to actively look for by way of behaviours so as to respond to and manage that risk. Similarly, this is not a case where the parents feigned compliance. During this period there was active resistance to social care involvement and threats against staff. Yet there is no evidence that CSC gave consideration to the impact that such an environment may have on the child living within those conditions or assessed his parents' ability or willingness to protect Adam from sexual harm given their response to concerns regarding neglect more generally. There is also no evidence in this case that a thorough assessment of his parents' motivation to change had been undertaken, or any

[10] SCR: Child I & M, Jane Wonnacott (2014)

thought given to the implications any failure to change within his timescales would have on his physical health and emotional development. The conclusion within the Child L[11] SCR, for the need for practitioners to focus on the welfare of the child as being the paramount concern over the demands of difficult parents, also have resonance to the way in which concerns about Adam's welfare were addressed during this period.

4.2 The finding in Family A[12] was that a failure to investigate following indications of sexual abuse '*cannot be attributed merely to a lack of thoroughness- it also suggests a reframing of the causes for concern into something easier to deal with'*.[13] In that report, the author recognised that nationally there had been a reduction of child protection cases where the principle category of concern was sexual abuse, but noted this was much more marked locally. He concluded there was no evidence that the decrease in numbers (from 30 in 2009-10 to 5 in 2012-13) reflected a decrease in incidence of intra-familial child sexual abuse. He concluded that '*failure to follow up the earliest concerns about sexual abuse was significant. It was easier for practitioners to feel that they could respond to neglect (and physical abuse) while keeping the children in the family. Had a thorough, structured assessment been carried out it is highly likely that this would have led to the identification of sexual abuse and that this would have led to the earlier protection of the children*.'[14] More recently, CSC reported findings of an internal audit undertaken on s47 enquiries initiated between September 2017- August 18 which found that 17.5% of enquiries (affecting 284 children) identified sexual abuse as an enquiry reason, with a third of these cases involving intra-familial sexual abuse. In the same period, 7.5% of Child Protection Plans (38 children) and 8% of single assessments (144 children) identified sexual abuse as a factor.[15]

4.3 As set out above, this review is not a critique of the work undertaken in 2014. Those reviews have already addressed the systematic failings identified at that time and made recommendations to improve practice in respect of assessment practice, information sharing and escalation procedures. Those reviews also made recommendations regarding managerial oversight of key decisions and that agencies ensure suitable opportunities are made available to assist frontline staff access reflective supervision. The LSCB and partner agencies within it have accepted those reports and previously reported, within subsequent annual reviews, of the work undertaken to secure assurance that actions have been taken to implement change.

4.4 There is evidence of learning from earlier SCR reports being applied in practice in this case. For example, throughout this case practitioners (including legal services staff) expressed concerns that M may not have been in a position to freely express her will. It is clear from CSC records that careful note was made of occasions when she appeared to acquiesce to PGF's unreasonable demands, her lack of participation in the Child Protection Conferences and her change of behaviour when her responses appeared to have caused upset or offence to F. Practitioners gave consideration during the RCPC to whether there was any evidence of domestic abuse within the house. Notwithstanding this, it is clear that opportunities were missed during that period to identify and robustly address the risk Adam may have faced of intra-familial sexual harm, given what was known to practitioners involved in the Child Protection process at that time. As this is the focus of this review, any further lessons to be learned from this case will be addressed within the substance of the period under review.

[11] SCR: Child L, Moira Murray (2014)
[12] SCR: Family A, Kevin Harrington (2014)
[13] ibid. pg 8.6.1
[14] ibid. 8.6.4
[15] Reported by CSC in response to further enquiries as part of this review.

Key Practice Episode 1: October 2013 - March 2015

4.5 In October 2013 Adam's school made a referral, concerned that his presentation suggested a high level of neglect. The local authority's children services carried out a single assessment. This is a combined assessment intended to replace the initial and core assessments, incorporating the three domains of the Assessment Framework Triangle. In line with local protocols[16] this should have been completed within 45 days and should have involved a separate interview with the children. It should also have involved observations of interactions between the parents and children. As part of this review, a senior manager undertook a quality assurance case review of the electronic records and reported that the single assessment report did not mention allegations against the paternal grandfather or uncle. This information was available to the assessor, as it had previously been disclosed as part of the earlier child protection process. The assessment was completed on the 20.12.13, slightly outside of the required timescale of 45 working days. The conclusion of the assessment was that the case should progress via a Child in Need plan due to concerns that the parents had refused to engage and because the property and parents also showed signs of neglect.

4.6 There is no obvious justification for the assessment's conclusion that the level of risk could be managed through a Child in Need plan. There was very little information within the assessment regarding the condition of the home, nor was this linked to Adam's presentation or developmental difficulties reported by his school as being the basis for their referral as a safeguarding concern. It doesn't appear that consideration was given to the previous interventions under the Child Protection process in 2009. Furthermore, very little activity appears to have been undertaken in response to the referral. The Quality Assurance review reports only that CSC's chronology was updated on the 26.02.14. Information contained within the previous chronology, setting out the context of concerns regarding neglect and the potential sexual risk posed by other adults in the household, was not transferred to the new chronology report. Had it been this '*should have highlighted the potential risk posed to these children*.'[17] The decision to support Adam as a Child in Need suggests a reframing of risk in the similar way to the failing identified within the Family A SCR. Certainly, case analysis was insufficient, as demonstrated by the chronology, given the information that was available to CSC.[18]

Learning point: Chronologies are vital sources of information to enable practitioners' to quickly identify or recognise pattern or escalation of need/ risk and therefore must be comprehensive. This requires that the lead practitioner is afforded time and access to relevant partners' records to collate this at the start of any new enquiry and used to inform practitioners' supervision and all CiN meetings and CP conferences.

4.7 Anna was born in 2014 and also made subject to a Child in Need plan as the concerns regarding the poor home conditions remained. It does not appear, from the papers made available during this review, that any services or support was provided to the family despite the decision in October 2013 that Adam (and, following her subsequent birth, Anna) were children in need. No further intervention was offered until Anna was discharged from hospital following her birth to her parent's care in March 2014.

[16] The current local protocol was published in August 2015. This would not have been available to staff practising in October 2013, but was devised to recognise expectations set out in national guidance, namely 'working together to Safeguard Children' 2013.
[17] Pg 4.1 Quality Assurance report, CSC
[18] Previous recommendations from SCR reports have focused on chronologies being up to date and available for all CP conferences (see p22, 2017-18 LSCB Annual Report). The LSCB may wish to seek assurance on whether practitioners are able to collate chronologies at the earliest opportunity to inform risk assessment.

4.8 The first Child in Need ['CiN'] planning meeting took place on the 24.04.14. There is no explanation within the minutes for the 6-month delay in setting up the first meeting and no explanation as to why, given the level, persistent nature of the neglect and significant impact reported on Adam's development, it was deemed unnecessary to initiate child protection processes or commence pre-proceedings plans under the Public Law Outline ['PLO'] process. There is also a lack of clarity on what action the parents or professionals should take to address concerns.

4.9 The level of inaction and poor decision making is particularly alarming given that two SCR reports were published by the LSCB in May 2014, both of which (as noted above) bore a number of similarities to the harm suffered by Adam and Anna. These decisions received no managerial oversight and were not challenged by other agencies involved in providing care to the children. Whilst CSC reported that additional protections have been put in place since 2014 to quality assure and track decision making regarding child protection, these may not apply to those supported as a 'child in need'.

4.10 Practitioners continued to meet and review the CiN plan during 2014 as detailed in the chronology. Minutes of those meetings suggest a lack of focus on the impact the home conditions were having on the children. The minutes don't report detailed descriptions of the actual home conditions; records are subjective in nature making it very difficult to ascertain if there is an agreed view that home conditions were of a level that placed the children at immediate risk of significant harm. School and health staff commented, during the practitioners' workshop, that the length of time between the referral and first meetings was not unusual for that period. This might explain why, despite the apparent drift, neither the CiN minutes or the Quality Assurance review report any escalation of concerns[19] by other practitioners involved in this case, or a request by the allocated worker for managerial guidance or oversight of the key decisions. This was a missed opportunity to provide any effective interventions to either affect change or gather evidence to justify more intrusive interventions to protect the children.

Learning point: Minutes of CiN meeting must accurately reflect the level and nature of concerns expressed by all professionals. They need to record, as a minimum, actions to be undertaken, by whom and within what timescale to address the needs of the child[ren]. They also need to set out what the Local Authority's contingency plan would be if action isn't taken or doesn't address the needs of the Child[ren].

4.11 In fact there is no record of any managerial oversight in this case until after a new social worker was allocated in July 2014 and a joint visit is undertaken on the 06.08.14. Prior to this there was unacceptable drift which went unchallenged by other agencies involved in Adam and Anna's care. Practitioners from Adam's school explained they would have tried to chase for action from CSC, but were unable to provide documentary evidence as their records had been forwarded to Adam's new school.

4.12 Following the change in social worker, there is a noticeable improvement in focus of the CiN meetings. The minutes (dated 18.07.14) detailed more explicitly the home conditions and set out previous non-compliance of the parents. The impact on the children was briefly described and the first CiN plan was created, though this did not receive managerial oversight until 31.10.16 (two years later when again the electronic records were being prepared for case closure). There is evidence at that meeting that practitioners were planning a contingency if the parents failed to demonstrate any improvements to the home conditions, namely to escalate to Child Protection processes if change wasn't forthcoming.

[19] An escalation process was published the LSCB (see http://southamptonlscb.co.uk/wp-content/uploads/2012/10/Early-Years-and-Child-Care-Safeguarding-Escalation-Process-.pdf)

Subsequently on the 06.08.14 the social worker initiated a further assessment under s47 Children Act 1989. The conclusion of the assessment was for child protection process to commence and for a further assessment to be undertaken by the Specialist Assessment Team. This was subsequently ratified at the CiN meeting on the 28.08.14. During this meeting staff from Adam's school clearly articulated the negative impact that his home environment had on his education and social development, but there is no evidence that the risk of IFCSA was considered at all.

4.13 An initial child protection conference was held on the 09.09.14. All agencies involved in providing support to the children were in attendance, with the exception of their GP who does not appear to have received an invitation. As part of this review, the GP did review their medical records and was unable to find any record that they had been asked to attend or contribute to this meeting. The GP acknowledged normal practice would to send ICPC minutes to the child's GP, but this didn't appear to happen (possibly due to an administrative error) and as a consequence the GP would not have been aware of the risks or of the protection plan.

4.14 The principle focus of the Initial Child Protection Conference was the risk arising from the '*unclean and unsafe home environment*'. The conference minutes did not identify sexual abuse as a category of risk, despite the family's offending history having been highlighted as a cause for concern that the children could be at risk of IFCSA. Practitioners involved at that time advised[20] this was probably because the '*horrific'* and '*appalling'* home conditions overwhelmed all other concerns. Conference Chairs have, as part of this review process, explained that nationally the expectation at that time was for Chairs to record need under only a principle category. In Southampton, this practice wasn't always followed (indeed at this meeting both emotional abuse and neglect are identified as risks).

4.15 The minutes indicate practitioners were aware that, in addition to the harm caused by neglect, Adam and Anna were at an increased risk of IFCSA, due to the type and level of offending behaviours reported within the adults in the household, some of which had resulted in convictions. The plan partly addressed the risk of sexual abuse; it included steps to gather more information from the police database and for CSC to carry out a face to face assessment of risk posed by other adults in the household. The parents were also required to sign a contract of expectation to limit all contact between the children and their paternal grandfather and uncle to supervise only. So it is implicit, though not clearly articulated, that practitioners did have reasonable cause to suspect that Adam and Anna might suffer significant harm if left in PGF or PU's care unsupervised despite F's assertions that they were innocent. Failure to articulate that risk at that initial meeting allowed F to assert (with M's support) that there was no evidence that PU or PGF posed a risk of IFCSA. This shifted the focus of attention for practitioners regarding their evidential burden away from whether F and M would, on this issue, act to protect Adam and Anna from the risk. Instead the focus moved to trying to evidence that IFSCA was taking place.

4.16 On the 24.09.14 CSC obtained legal advice regarding escalating this case to the Public Law Outline ['PLO'] process. Lawyers attending the practitioners meeting confirmed there was sufficient evidence[21] to demonstrate the threshold for child protection proceedings[22] would have been met at this time given the persistent nature of concerns, lack of any sustained improvements and direct parental non-compliance with the CiN plan. However, they also agreed it may not have been possible to seek immediate removal of the children from the home on the evidence as presented at that time. For this reason, CSC

[20] During the practitioners workshop discussions

[21] The lawyer who gave the legal advice on the 24.09.09 was not present at the professional meetings as she had subsequence moved away from the authority.

[22] s31 Children Act 1989

were advised by Legal Services to gather more information and undertake further assessments (including updates from Sure Start and Communicare) before initiating the PLO pre- proceedings process. The social worker was advised to request a further legal planning meeting if there was little or no sustained change within 4 weeks and refer to the Specialist Assessment Team ['SAT'] to obtain a cognitive assessment of both parents and their capacity to care for the children. It is noted that the lawyer provided assistance, by drafting a letter of instruction, to secure the cognitive assessment in a timely manner. The Specialist Assessment Team, however, later confirmed they could not complete the parenting assessment, because access to this service was restricted by internal agreement to only those cases subject to the PLO process. Had Legal services been aware of this restriction it is likely they would have taken this into account when deciding whether to initiate the PLO pre-proceedings process. This was a missed opportunity to escalate this case into pre-proceedings, which would have provided a mechanism for collating evidence in a format acceptable to the Family Court.

Learning Point: LPM minutes need to carefully record evidential basis for decisions, even if this is not to initiate pre-proceedings or proceedings under the PLO. Mechanisms for tracking case progression, set up in response to earlier SCR findings, need also to be robust and make clear who has lead responsibility for monitoring progress. These should enable both legal services and CSC practitioners to escalate if no apparent action is taken within agreed timescales.

4.17 The social worker (together with a colleague) completed assessments on the risks posed by PU and PGF of IFCSA, meeting with the paternal uncle and paternal grandfather in early October 2014. The outcome of the assessment and recommendation for supervised contact was communicated to the parents, the paternal grandfather and uncle on or around the day of this assessment. The parents also signed the contract of expectations confirming that they would supervise all contact at that time. Practitioners were advised of the recommendation at the subsequent Review Child Protection Conference ['RCPC'] on the 26.11.14. Discussions at that meeting indicate parents had signed the contract of expectations, were aware of the risk of IFCSA and their role in preventing this to protect the children. The findings of the cognitive assessment (undertaken in November 2014) confirmed that neither parent presented as having low cognitive abilities, supports the view that it was reasonable for practitioners to rely on the parents' assurance they understood their responsibilities and the implications if they failed to adhere to the contract.

4.18 Despite this, in early December, Adam is sent home from school (unwell) in the sole care of his paternal uncle. The incident is reported immediately by the school to CSC and CSC subsequently carried out a home visit (5 days later) noting that Adam was '*observed to be destructive in his play and negative towards police.*'[23] His parents were reminded of their obligations and the school confirm they had amended procedures to ensure this wasn't repeated. School and social care staff also agreed contingency arrangements to prevent a reoccurrence, namely that school staff would accompany Adam home in future if necessary. Within the same week Anna is found, during a home visit, to be in the care of PU and PGF without supervision. Concerns are escalated to the emergency duty team who conduct a home visit over the weekend to again remind the parents of the need to adhere to the contract of expectations in order to safeguarding the children. Both incidents are recorded within the social care records and reported subsequently within Review Child Protection Conference ['RCPC'] reports. Neither the Police or Legal services were advised of this breach. Had this been reported to MASH, the police would have been able to assess and grade the information to determine the appropriate course of action. Similarly, legal services

[23] Reported within SCC's CSC chronology submitted as part of the review.

reported to this review that notification of this failure would likely have triggered a decision to initiate s31 proceedings or at the very least go into pre-proceedings under the PLO process.

Learning point: Working Together guidance underlines the importance of multi-agency involvement in mitigating risks. For this to be successful, all practitioners involved in supporting the child[ren] must be fully aware of the evidence on which any risk management plan is based. All risk assessments undertaken, including with adults coming into regular contact with the children, should be shared with agencies involved in the CP process.

Equally, a protection plan needs to accurately reflect partners' roles and address any limitation to their legal powers to intervene, giving clear guidance on expected responses if breaches occur and/or child[ren] are put at additional risk.

4.19 Managerial oversight was first formally provided on the 14.01.15 in a supervision session. The details of the wider family members offending history is discussed, together with the breaches in December 2014. It doesn't appear from the supervision record, whether any advice was offered to the lead professional to manage the risk of IFCSA whilst the children are in the family home or if she was advised whether there were now sufficient grounds to initiate the PLO process. Supervision discussions did not prompt a request to legal services for further legal advice, it is therefore reasonable to conclude no such guidance was provided. It should be noted that none of the supervision records submitted as part of this review record the rationale for decisions made at that meeting. It is clear within the LSCB's 'principles and standards for safeguarding supervision' that it is the responsibility of the supervisor to ensure this.

4.20 From January to March 2015 the parents receive specialist support through the protective parenting sessions. This concluded they failed to understand the impact that neglect would have on the children and that they viewed this intervention as a '*tick box exercise'*. Practitioners also reported on the impact as evidenced by Adam's presentation. His school reported his ability to communicate was severely affected during holiday periods and his social worker undertook some 1:1 work with Adam. As a consequence of a further breach (mother refusing access) and the reports regarding Adam's presentation, CSC made a further referral to SAT for 'protective parenting' sessions and sought advice from legal services regarding escalation to PLO processes.

<u>Key practice episode 2: April 2015- July 2017</u>

4.21 By April 2015 legal services confirm that there are sufficient grounds for concern to initiate PLO pre-proceedings process. CSC were advised to write up an assessment report regarding the parents' capacity to care the findings following CSC's recent interventions, including the SAT change work which focused on the basic care and home conditions. Legal services later explained the decision to commence a pre-proceedings process under the PLO rather than initiate proceedings was likely because, given the length of time CSC had been involved in the case, the Court would have expected this assessment to have already been made available to the parents at the PLO pre-proceedings stage, i.e. prior to issuing proceedings under s31 Children Act 1989.

4.22 A meeting was arranged in early May 2015 as part of the PLO process which both parents attended with a single legal representative. Again there is no explicit reference that the children could be at risk of IFCSA, rather the focus was on the persistent nature and severity of neglect and the impact this has had on the children's development. The requirement that the parents comply with an assessment of their capacity to care and sign a contract of expectations was discussed. This contract included the need to maintain supervised contact with PU and PGF and the parents were asked to sign a further copy. The parents are recorded as having stated '*they do not accept the concerns as to why the*

paternal grandfather and the paternal uncle are of concern, they accept that the children are not to be left unsupervised'. Again, whilst the risk of sexual harm is not specified within the contract as the rationale for requiring supervised contact with PU and PFG, it was clearly understood to be the motivation behind the request for supervised contact. This is referenced at the next RCPC in May 2015 where CSC staff raise concerns about the parents' ability to protect the children given their non-adherence to the contract. Again it doesn't specify sexual abuse as a category of need and nor does this prompt escalation to seek the initiation of proceedings despite the length of time parents had been supported to implement a change in their ability to care.

4.23 As part of the change/ intervention work with the Specialist Assessment Team, F disclosed two of his maternal cousins had Children's Services involvement previously. That was due to concerns regarding parental failure to protect following sexual abuse of one child (by a person in a position of trust). Father disclosed that the victim later performed sexual acts on a sibling. Again this disclosure underlines his understanding of the risk IFCSA poses and should have reinforced his commitment to protecting the children. Despite this, the contract of expectation remained unsigned. It may also have justified practitioners reviewing their risk assessment, concerned that for F such abuse might be his normal. There is no indication that this further disclosure was used to review F's capacity to protect the children from IFCSA.

4.24 Between April 2015 to January 2016 SAT concluded to offer support to F and M, concluding there were significant ongoing concerns regarding, in particular, F's ability to improve within the child's timescales. They reported the parents were often late to sessions and appeared mistrustful and hostile at the start of the process, but that M appeared more willing to engage. Their '*reticence to move away from PU and PGF*' was identified as a barrier to change within the children's timeframes. SAT concluded M and F's '*relationships were enmeshed*' with PU and PGF.[24] They remained concerned that M and F had no plans to reorganise roles within the family to address areas of concern identified by professionals.

4.25 The social worker completed the 'capacity to care' assessment report in August 2015 recommending proceedings commence. The social worker was due to take schedule long-term leave in early September and so escalated concerns that the case should be issued urgently. The social worker clarified, during the course of this review, that immediate removal was justified in the circumstances that existed at that time but felt that others (predominately senior CSC management) may not have been of the same view; it was for that reason emails were sent requesting child protection proceedings commenced even if the Local Authority did not seek removal immediately. The request for oversight from the principal officer was not responded to, practitioners advised this was very likely due to the principal officer's own workload pressures at that time. Similarly, there is no information within the supervision records of that time of any managerial advice offered regarding escalation to proceedings. As a consequence, the planned legal meeting had to be rescheduled and in fact didn't occur until mid October 2015. By this time a new social worker had been allocated as lead professional. Practitioners involved in this case agreed this represented the most significant missed opportunity to safeguard Adam and Anna.

4.26 The newly allocated social worker interpreted the capacity to care assessment far more favourably, which practitioners believed may have been attributable to F's manipulation. It is noted that the newly allocated social worker attributes the parents' hostility and failure to adhere to the contract of expectations to F's 'gender issues' with the previous allocated worker, the assumption being that F refused to comply with instructions from professionals if they were female. The previous lead social worker, as part of this review, confirmed that they had recognised that a change in allocated worker might increase the risk

[24] SAT intervention plan review report

of further drift and that this concern had been raised to team manager level. It is also noteworthy that, the change in social worker coincided with a change in team manager responsible for oversight. There was notable distress at the practitioners meeting in July 2018 that, despite the very clear risk assessment and significant evidence gathered over many months, the opportunity to protect Adam and Anna from the maltreatment was missed at this time.

4.27 On the 22.10.15 a RCPC took place. There are a number of factual inaccuracies detailed within the RCPC minutes that even a cursory review of the recent assessments should have uncovered. For example, the parents are reported to be '*engaging and have done a lot of work…* [The parents are] *agreeable to home visits*'. There was a discussion regarding the previous breaches of the contract of expectations, but again F appears to dominate discussion and doesn't appear to have been challenged by the Chair or any practitioner when he minimised the number or importance of the breaches or indeed his culpability for those. There is also little to no follow up to ensure the plan had been actioned, for example, the new lead social worker is tasked with drawing up a contract of expectation for PU and PGF to sign and provide all parties with copies. M and F are required to contact their GP and request therapeutic input to address their own needs. It does not appear from the materials submitted in this review, either were ever actioned, nor are the reasons for not doing so recorded or used to inform the risk and protection plan. There is also no challenge regarding the considerable drift.

4.28 Again the risk of IFSCA isn't specified and nor is the failure by the parents to find alternative accommodation recognised as aggravating this risk, despite this having been identified as a key step for the parents to take to protect Adam and Anna. Concerns regarding Adam's presentation were described as '*not inappropriate as such. He is a very tactile boy, every time I go round from my second visit he came for a hug. An issue with social boundaries*'.[25] The focus seemed to shift from investigating the parents' ability to protect Adam and Anna from the risk posed by living in a household with their PU and PGF to training Adam to understand 'social stories'. There is reference to the school implementing a 'keep safe' programme for Adam to be reinforced at home, but there is insufficient detail to ascertain whether the core purpose behind that programme was to verify whether Adam was experiencing sexual abuse. It appears unlikely that this would have been the focus, however, as that should have required specialist police input. There is no explanation in this (or in any previous RCPC minutes), why police involvement wasn't directly requested.

4.29 During this period the school nurse service was also re-commissioned. Previously the contract had required attendance at all RCPC meetings for children of school age. As part of the newly commissioned public health service, where cases did not have an unmet health need, the service were not actively involved with the child / family. However, if a need was identified as part of the review conference and the public health nurse required to provide intervention, the social worker would be able to request involvement from the service. Whilst both the health visitor and public health nurse (linked to the school) provided a report and attended the RCPC in October detailing their ongoing concerns and the presentation of the children, the change in commissioning arrangements did have a practical implication in this case. Thereafter, the public health service was not part of the ongoing information sharing in relation to the family. As part of the review, the public health nurse was able to report that, having come fresh to the case, it appeared that the only issue relevant in this matter was parenting capacity and finding alternative accommodation for the family due to concerns regarding the ongoing poor conditions of the home. As a service,

[25] RCPC minutes

they had not been aware, indeed until asked to attend the practitioners meeting at part of this review, that there was a risk of sexual abuse in this case.

4.30 There was evidence that, throughout October and November 2015, legal services emailed the lead social worker (copying in the team manager) for instructions and advised that threshold to commence proceedings was met. There was no response, but the case was not escalated to the principle social worker until late November when concerns are raised that assessments might be viewed by the Court as out of date. Legal services were also in contact with the parents' legal representative to set up a further pre-proceedings meeting throughout this period, but were unable to set up a meeting until 15.02.16. There is no evidence of any managerial oversight or interventions despite the complexity of this case and the fact that the lead social worker had protracted periods of sickness during this period and eventually left their post in early January 2016. The lack of managerial oversight continued, in that the case remained unallocated until later that month.

4.31 In early December 2015 Adam, Anna and their parents moved into their own accommodation away from their paternal grandfather and uncle. A home visit shortly after the move reported that Anna was seen to be left in her pushchair for a long time and 'grubby', but the move prompted social care to agree to a further period of assessment to ascertain whether the parents could improve the home conditions.

4.32 The new social worker had, by 26.01.16, secured agreement from F to sign the contract and set up a further meeting with him and his legal representative to review whether sufficient progress had been made under the PLO process. Again, M's non-attendance isn't challenged despite the meeting having been arranged so as to facilitate her attendance and, largely due to the house move, CSC were advised to conduct a further period of assessment to ascertain if any improvement to home conditions could be sustained. There is no evidence that the risk of IFCSA is reviewed or considered. During a home visit that month F remarked that he hoped PU and PGF aren't molesters. Regular home visits were conducted and the PLO and CP processes continued.

4.33 It is notable that on one occasion in late February 2016 the social worker reported that F had initially tried to frustrate a home visit and appeared '*intimidating and annoyed*' when the social worker demanded entry into the home and challenged F regarding his assertions that fresh food was prepared for the children. The social worker confirmed she had a good understanding of the concerns and evidence basis for the earlier 'capacity to care' recommendations. During conversations held as part of this review process, she recognised that this behaviour was very similar to the presentation that had given rise to the earlier conclusion that the parents' didn't have capacity to change within the children's timeframe but explained that, in her experience, an isolated incident would not provide sufficient evidence to justify re-escalation or the initiation of care proceedings particularly given the improvements that had been noted to the home conditions and interactions between the parents and children. Nevertheless, weight was attributed to this incident as evidence by its inclusion within capacity to care addendum report to provide balance to the overall impression of the parents' willingness to accept professional support and their capacity to sustain change.

4.34 In March 2016 the Chair of the RCPC challenged practitioners regarding the length of time the children had been subject to CP and PLO processes. The change of address and improvements to the children's care were noted. It was universally assumed the move away from the address shared with PGF and PU had reduced the risk of IFCSA. It was made explicit within the reports provided by school that the contract of expectations regarding the PU and PGF needed to remain in place to *'protect the children from being left in their care at*

any time'.[26] In addition, the social work report did recognise that a lack of clutter might in part be due to the '*short period of time and minimal amounts of furniture and other personal items*'. The report detailed times when F had become 'defensive and argumentative' when challenged by the social worker or had not followed through with actions under earlier plans to seek a referral from their GP for therapeutic input to address their own historical and emotional issues. It highlighted that F wasn't '*working in an open and honest manner with the local authority regarding the children's dietary needs and that M had not attended Core Group or PLO meetings despite these being arranged in advance to facilitate her attendance*'.[27]

4.35 There is evidence within the reports and subsequent minutes of the conference that practitioners undertook detailed consideration of the previous capacity to care assessment and weighed improvements to home conditions against the children's presentation and developmental progress. Both children's speech, despite significant interventions, were reported as still delayed due to poor home environment. The Chair stated '*a long period of further child protection is not an option'*.[28] Practitioners concurred that the CP plan was being progressed but '*not in a timely way'* and that there is insufficient evidence to conclude that improvements to the home conditions could be sustained. They unanimously agreed that a further short period (3 months) was needed and the social worker was tasked with completing an addendum report on the parents' capacity to care.

4.36 The addendum capacity to care report, completed in August 2016, does identify the risk of IFCSA posed by PGF and PU as a key area of concern. It details the discussions the social worker had with both parents regarding their views of the risk posed by PGF and PU of IFCSA and concludes M and F '*are minimizing the local authority's concerns and do not feel that his father or brother could ever be a potential pose a risk to* [Adam and Anna] *due to them being found not guilty. However, both parents did identify that the children could be at potential risk being left with [PU] as they feel he is incapable of keeping the children safe, which shows the ability to recognise risk and put safety measures in place to keep [Adam and Anna] safe*. [The parents] *are fully aware of the local authority's concerns with regards to* [PGF and PU]*. I have stressed to them both the importance of not allowing [PGF and PU] to have unsupervised contact with* [Adam and Anna] *and the consequences if they did. Both [parents] have agreed that they will not allow any unsupervised contact throughout the children's minority*.'[29]

4.37 In line with the recommendation of the addendum report, a pre-proceedings meeting took place in August 2016 shortly before the RCPC which confirmed that the matter would de-escalate and that, subject to approval of practitioners at the RCPC, the case would step down from the PLO and CP processes. This was subsequently confirmed at the RCPC despite both the health visitor and the social worker identifying within their reports to the RCPC a lack of evidence to confirm either way whether contact had been and would continue to be supervised. During the conference both parents were questioned about how frequently they had contact with their extended family and provided assurance that they will continue to supervise all contact with PU and PGF. The Conference Chair also identified as the principle concern that the children would be at significant risk of harm were they to have unsupervised contact with PGF or PU. In addition, it was made explicit to parents that they would need to maintain supervised contact and continue to meet the children's basic and developmental needs and that, should concerns regard neglect re-emerge or there was any evidence of the children having any unsupervised contact with PGF or PU the local authority would seek legal advice to '*ensure the children are appropriately safeguarded in the future'*.

[26] School agency report, submitted for RCPC dated 15.03.16
[27] CSC agency report, submitted for RCPC dated 15.03.16
[28] RCPC minutes, dated 15.03.15
[29] page 8, Capacity to Care Addendum report

It is now known that, throughout this period, PU was able to abuse both Anna and Adam. Whilst the parents later claimed that they had not appreciated the risk that he posed to the children, that assertion is simply not plausible.

4.38 There were three further CiN meetings between August and November 2016 when the case was closed to CSC. The meetings' minutes suggest there was an assumption by both parents and practitioners that CSC would withdraw from the family shortly. At the final meeting there was unanimous agreement that progress had been sufficient and sustained so that it was no longer necessary for CSC to remain involved. Notably, attendees from Adam's school and Anna's pre-school confirmed parents were engaging well and that they felt they would ask for help if needed; the parents also confirmed they that would seek support if required. It had previously been agreed (at the RCPC) that the schools would continue to monitor and re-refer if concerns re-emerged.

Thematic analysis of practice issues

Was adequate consideration given by practitioners to the risk of sexual abuse, given disclosure of past concerns regarding intra-familial sexual abuse?

5.1 There is some evidence that practitioners involved in protecting Adam and Anna had identified the risk to them of intra- familial child sexual abuse, but what emerges is inconsistency in how to articulate this risk, gather evidence and apply that in a forensic way on a consistent basis to ensure that risk assessment informed the child protection and PLO processes.

5.2 That said, there was little or no recognition of this risk during the first assessment or CiN planning process in 2013-14. This information was known or ought to have been known to the lead social worker in the case, but does not appear to have been shared with other practitioners who may have been well placed to support risk analysis and information gathering. For example, the health visitor's notes from that time suggest that service was unaware of the potential risk of sexual harm the paternal grandfather and uncle may have posed; they identify the PGF and PU as supportive factors within the household. As with CSC's involvement, the focus of the health visitor's involvement at this time was the poor home conditions. In addition, although the police were notified of an unannounced home visit to the family home on the 06.08.14, they were only made aware of the concerns regarding neglect and not asked to advise regarding any risk of IFCSA as part of that enquiry. As a consequence, the CiN meetings in 2014 did not acknowledge risk of sexual harm; there was no assessment of the risk of IFCSA and no real plan or timescales set out to help the family access their own accommodation away from the paternal grandfather or paternal uncle. The single assessment (dated 28.08.14) briefly considered the risk of sexual harm, commentating on the '*concerning criminal history of paternal grandfather and uncle'* and recommending that checks were undertaken with the police to ascertain if those individuals posed risk to children.

5.3 The risk of IFCSA was only addressed at the Initial Child Protection Case Conference on the 09.09.14, almost 11 months after the initial concerns were raised with CSC. There is no evidence of any multi-agency discussions to ascertain, before this meeting, the precise nature of the risk or discuss what role each agency might take in assessing the risk or collating information so that there was a shared understanding of the nature and level of risk posed by the PGF or PU. The minutes indicate that F dominated the discussion regarding the historical allegations of sexual abuse made against his father and brother, dismissing these as a cause for concern because there was not sufficient amount of evidence at that time to convict. This was not openly challenged by practitioners at that meeting, despite all involved later confirming they were aware that the standards of proof which applies within civil proceedings is different to that required in criminal matters. It is notable that, whilst some practitioners understood that a verdict of 'not guilty' or a decision not to continue with a prosecution might not mean that the sexual abuse had not occurred, school staff commented that they had previously been advised that they had to treat someone found 'not guilty' as innocent, but couldn't recollect whether this was said in relation to this case.

5.4 LSCB partners will need to reflect whether policy and guidance to staff fully supports effective decision making which properly reflects Baroness Hale of Richmond's guidance on this issue, namely that it is only when the nature of civil proceedings are to punish or deter criminal activity they must produce evidence to meet the criminal standard of proof (beyond reasonable doubt). In all other civil proceedings, including child protection applications for care orders under s31 Children Act, it is the civil standard of 'balance of probabilities' that applies. She advised "*neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in*

determining the facts."[30] Details of the previous allegations and convictions should have been more carefully explored by practitioners, preferably prior to the ICPC to ascertain what records existed regarding the previous investigations, whether there remained an evidential gap and what information might be needed to properly determine whether, in the views of the practitioners, there was reasonable cause to suspect that Adam and Anna were suffering, or were likely to suffer, significant harm[31] through unsupervised contact with PGF and PU.

Learning point: All practitioners benefit from understanding what evidential standards need to be established before practitioners can justify using any legislative powers to investigate (under s47 Children Act or the Police and Criminal Evidence Act 1984) or initiate proceedings (under s31 Children Act and for criminal offences).

A 'reasonable cause to suspect' a child is at risk of significant harm justifies s.47 investigations. For police officers to exercise their powers of arrest they must have reasonable grounds to suspect an offence has been committed and that the arrested person has committed it. Police officers must also have reasonable grounds for believing that it is necessary to arrest the person.[32]

Clearly, it may be possible to carry out an investigation without using powers of arrest, however, once that threshold is crossed (e.g. for ill-treatment/willful neglect or sexual offences) officers can proactively searched for evidence of IFCSA.

The standard of proof needed to secure an Interim Care Order under the Children Act is higher than for an investigation. It requires 'reasonable grounds to believe' the children were at risk of significant harm and that the harm, or likelihood of harm, is attributable to the care given to the child not being what it would be reasonable to expect a parent to give.[33] In addition, in order to approve removal of children from parental care under an Interim Care Order, the court must be satisfied there is an imminent risk of harm such that the child's safety demands immediate separation.

CP Conference Chairs should check that all participants in any CP plan have a common understanding of the importance of any information shared, what powers relevant agencies have to make enquiries and the expectations for recording and reporting information relevant to the CP plan so that information is shared in a way that facilitates effective enquiries, taking into account relevant agencies' legal powers.

5.5 As set out in s1.1 the arrest and conviction of PU in July 2017 established that both Adam and Anna suffered IFCSA at both the family home and at the PU's address during 2016-17. Although practitioners were cognisant of the potential risk to Adam and Anna of IFCSA, it must be acknowledged that they could not have known in 2014 that this abuse would take place and the police did not have reasonable grounds to suspect any sexual offences had been committed against Adam and Anna during that period thereby warranting use of their arrest and search powers. . Studies[34] indicate that the level of IFCSA is rare, with between 0.5- 1.2% of respondents reporting contact and non-contact sexual abuse by parent/carers of children under 11. It must also be acknowledged that research accepts that '*adult perpetrated child sexual abuse in the family environment is possibly one of the most difficult context in which to identify children at ris*k. *Many of the strategies and techniques used by perpetrators to target, isolate, groom and abuse children may obscure within*

[30] in *Re B* [2008] UKHL 35, pg.70
[31] s47 Children Act 1989
[32] e.g. because it is necessary to protect a child or other vulnerable person from the person in question[pg2.9d] or to allow the prompt and effective investigation [pg2.9e- Code G, PACE Code of Practice for Police Officers.
[33] Or that the child is beyond parental control, see s38 and s31 Children Act 1989
[34] Radford et al, 2013 and Cawson et al, 2000 quoted within Debra Allnock's research report at p7, ibid.

'normal' activities that that one would expect a parent or carer to engage in with their children. Furthermore, it is the close, trusting relationship- both of the parent to a partner and a child to a trusted parent/guardian- that can make this form of abuse so difficult to identify'.[35]

5.6 Allnock's research highlights further complications to identifying IFCSA when neglect is also a factor in a child upbringing which may make perpetrators' strategies easier to carry out and more difficult to detect. She cites Finkelhor's four preconditions model of child sexual abuse, namely:

1. Perpetrators motivation to abuse: these may arise from emotional congruence with a child, sexual arousal to a child and/or 'blockage' when alternative sources of sexual gratification are not available or are less satisfactory.
2. Perpetrators must also overcome internal inhibitions to abuse: Abel et al identified cognitive distortions function to justify (to the perpetrator) the abuse of children. Whilst it is unequivocal that children are, of course, **never** responsible for the abuse Allnock recognised the possibility that children who are neglected may, however inadvertently, send signals which chime with such cognitive distortions, e.g false notions that they are not harming the child or may convince themselves that they were supporting a child who is without love and affection from their primary caregiver.
3. Overcoming external inhibitions to abuse: Abusers will find it easier to gain access to a child where they are already isolated, withdrawn and/or experiencing impacts of neglect. Perpetrators of IFCSA may also encourage mothers to have more of a life outside the home in order to increase opportunities to abuse their victims[36] or 'babysit' so they can isolate a child.[37] Poor parent-child relationship is a risk factor. Finkelhor found that parents self-reporting neglectful behaviours was a strong risk factor for child sexual victimisation because it is precisely the type of vulnerability that perpetrators seek when they are planning to abuse a child. Supervisory neglect will increase risk, but it is important (particularly in this case) to highlight that a study[38] found a large proportion of sexual offending occurred when a potential guardian was present, though having a guardian in the vicinity could decrease duration of sexual abuse and occurrence of penetration (by 86%).
4. Overcoming a child's resistance to abuse: research literature reveals that perpetrators use a range of strategies to build trust and groom children. Allnock's paper highlights that a child who has experienced neglect may not have the confidence or ability to recognise boundary violations or the confidence to seek help. Emotional deprivation also places children at risk by depressing their self-worth, esteem and confidence, making perpetrators powerful figures in their lives. Delayed cognitive development also increased the difficulty in detecting abuse, particularly where this may be continually declining due to the cumulative impact of neglect as it may impact on a child's ability to understand that IFCSA is abusive and a crime.

5.7 Practitioners reported that, whilst they were aware of potential indicators of abuse[39] the level and impact of neglect was such that it is likely that it did impede their ability to detect sexual abuse at the earliest opportunity. With the benefit of hindsight, it is easier to see how many of the risk indicators, particularly in respect of the external inhibitions and the children's ability to recognise and report the abuse, applied in this case. It is clear, however, the risk was recognised at the Initial Child Protection Conference. That plan required the social worker to complete a risk assessment of the risk posed by other adults in the household, police agreed to review and disclose all pertinent information and the parents

[35] Debra Allnock's research report at p16, ibid
[36] Craven, Brown and Gilchrist, 2006 quoted within Debra Allnock's research report at p18, ibid.
[37] Elliot, Browne and Kilcoyne, 1995 quoted within Debra Allnock's research report at p18, ibid.
[38] Leclerc, Smallbone and Wortley (2015) quoted within Debra Allnock's research report at p19, ibid.
[39] for example, school staff confirmed they were aware of and applied the 'Brook Sexual Behaviours traffic light tool'

were asked to sign a contract of expectations which included a requirement for no unsupervised contact between the children and PGF or PU.

5.8 Furthermore, the assessments of risk posed by PU and PGF were well informed. They addressed the preconditions model set out in Finkelhor's research. The minutes of those meetings indicate the historical allegations made against both the paternal uncle and grandfather were explored in detail. They also explored the wider family context, developmental experiences of both men and their views on the impact that such experiences would have on children, including those who had made the earlier allegations. The responses then informed a risk analysis which took into account research guidance on motivational factors and indicators of likelihood of immediate offending re sexual abuse. They both concluded that the children should be supervised at all times when in the presence of either the paternal uncle or paternal grandfather.

5.9 CSC's quality assurance review comments that the recommendation '*relates predominately to their social circumstances and so not directly correlate to the level/nature of sexual risk posed by either individual (noted that much of this information is not known due to both of their denial)*'.[40] It also suggested they were '*an administrative exercise and that the expected outcome was already predetermined'.* [41] This concern appears to have arisen because, prior to this, the parents had agreed (as part of the ICPC plan) to sign a contract of expectations confirming that all contact between Adam, Anna and their PGF and PU would be supervised. Notwithstanding this, the assessments appear to robustly consider the risks to the children given the circumstances as they were understood. Practitioners had been careful to avoid an assumption that either PU or PGF were guilty of the allegations made in 2003. Given the nature of the risk and the application of the risk factors as documented within the risk assessment, the criticisms are unjustified. The assessment findings and recommendations strike the correct balance between the duty on the one hand to protect the children from a possible source of harm and, on the other hand, respect the family's rights protected under article 8 of the European Convention of Human Rights.

5.10 As Munro[42] advises dynamic risk analysis must be seen as a '*tool which complements professional judgment and encourages constant and critical review and reflection rather than an end in itself*'. White[43] recommends that, before responding to an assessed risk practitioners should acknowledge what may also shape their responses to that risk, e.g. preconceptions based on experience, opinions on the person's ability to recognise risk and respond appropriately to it, anxiety about the possible consequences and the organisational culture in which they work. She also highlights the importance of leadership and having a governance structure that trusts and supports staff. She advises that any risk assessment process should include opportunities for practitioners to engage with other agencies and their internal governance processes to reflect on whether proposed protection plans change the situation to reduce risk to acceptable levels whilst still respecting the voice of the child and promoting their welfare.

5.11 Whilst the risk of IFCSA had been properly considered, there was inadequate consideration then given to how to manage the perceived risk. The lead social worker wasn't directed to explore with F or M whether they accepted those findings, nor had any interventions been offered to adults within the household which might have reduced the risk of any offending. There was no preventative action taken to support Adam or Anna to recognise and report if abuse did occur. Nor does it appear to have formed part of the instructions to the educational psychologist asked to support Adam's difficulties with speech,

[40] p3, pg4.2 Quality Assurance report, CSC
[41] ibid
[42] Munro, E (2011) The Munro Review of Child Protection: Final report0 A child centred system, London Department for Education
[43] 'Safeguarding Adults Under the Care Act 2014' edited by Dr Adi Cooper and Emily White (2017) JKP publishers

language, comprehension and social skills. This is a significant gap in effective planning as a subsequent recommendation within the RCPC to address his 'preference to be tactile with other children' focused on enhancing his understanding of how he should behave. Given the perceived risk, this should have been identified as a potential indicator of abuse and, had it been, could've provided sufficient justification to require parental consent to special staff (either from the police or forensic child mental health services) exploring directly with Adam whether his behaviours were due to sexual abuse.

5.12 As part of the review CSC have confirmed they are exploring the development of a 'virtual team' so that child protection practitioners can receive special clinical support to work with potential perpetrators, particularly if (as would have been the situation in this case) the perpetrator is not known to Probation or any Offender Management service. The Building Resilience and Strengths service also confirmed they ran a drop in session for practitioners working with children at risk of sexual abuse, but reported this support was rarely used.

5.13 Lack of alternative strategies meant that practitioners relied solely on the requirement that the parents sign a contract of expectations. It is alarming that, only a few days after completing these, CSC provide advice to the school that it would be permitted for them to allow other children to visit on play dates. This suggests that this risk assessment was confined to a stand-alone process and not used effectively to inform protection plans for Adam, Anna or other children who might come into contact with PU or PGF.

Learning point: Risk assessments must trigger consideration of what action is needed to support professionals and any adults involved in the lives of a child to reduce ALL perceived risks. They must also be shared with those involved in the child protection process.

5.14 A thorough review of all documentary evidence was undertaken to ascertain whether practitioners reframed risk (as occurred in SCR: Family A)[44] to a type easier to deal with whilst the children remained living at home. Whilst the lack of explicit mention of sexual abuse within Child Protection Conference minutes and the contract of expectations might suggest this was a factor, on balance there is sufficient evidence to conclude this was not a conscious action. There are numerous examples where practitioners identify and report practice that heightens the risk of IFCSA, e.g. the work reported below [pg 5.42] and detailing within the capacity to care assessment of parental non-compliance and '*frustration at not being able to leave the children in the care of PU and PGF.*'[45] Furthermore, during the practitioners meeting all attendees confirmed they recognised this was always a clear risk, though accepted it was often masked by the overwhelming concerns regarding neglect. They also universally accepted that it should have been more carefully identified and recorded as a primary source of risk and that failure to do so possibly afforded F and M opportunities to avert attention from their own deficiencies to adhere to expectations to minimise the perceived risk.

5.15 It is also very likely that failure to frame the need for M and F to supervise contact in order to protect Adam and Anna encouraged their misconception that breaches would give grounds for concern only if IFCSA could be proven. Instead it should have been made explicit that the breaches would be used to evaluate if M and F's had capacity to protect Adam and Anna, as practitioners were already satisfied that there was reasonable cause to suspect they may be at risk. Crucially, it was parental ability to protect that would have been of relevance in any Child Protection proceedings under s31 Children Act, rather than the need necessarily to evidence criminal activity had occurred. The shift in focus at the earliest stage of the child protection process, though unintentional, could be seen as a barrier to effective safeguarding in this case. Had this been fully understood, the repeated failure to

[44] reported above in pg4.2
[45] pg8.2.6 of the Capacity to Care Assessment report, but also at pg 8.5.6

supervise all contact despite clear articulation of perceived risks could have been presented as 'reasonable grounds to believe the children were at risk of significant harm' as early as December 2014.

Was the 'voice of the child' given sufficient weight by all services and appropriately responded to for referral/ escalation

5.16 'Working Together' guidance requires that professionals involved in child protection work carry out their functions in a child-centred way. This means '*keeping the child in focus when making decisions about their lives and working in partnership with them and their families*'.[46] It is also clear that duties placed on the local authority can only be discharged with the full co-operation of other partners. Furthermore, guidance on responding to sexual abuse reminds all frontline staff they '*should not let other consideration, like the fear of damaging relationships with adults, get in the way of protecting children from abuse or neglect'*.[47] The narrative above provides an overview of the notable contact with the family from various agencies for the period under review and relevant to the issue under review, namely IFCSA. Details of observations of the children are set out alongside the events. It does not detail every contact, for example RCPC minutes detail many more home visits were undertaken between each of the RCPC. The health visitor and school nurse also met with the children on a regular basis throughout this period. Adam and Anna also had very regular contact with practitioners within their school and pre-school respectively. Those practitioners reported information into the Child Protection Conference process and notable contact is reported within the narrative above.

5.17 The chronology and case records suggest very little importance was given to securing the voice of the children at the point where services responded to the initial referral in October 2013. There is no mention of the risk of IFCSA, considerable delay in commencing the CiN process and no offer of support within the assessments undertaken in 2013. Nor was the persistent nature of the neglect and significant impact reported on Adam's development articulated in a way that could enable effective child protection processes or the timely initiation of the PLO process. The level of inaction and poor decision making is particularly alarming given that two SCR reports were published by the LSCB in May 2014, both of which (as noted above) bore a number of similarities to the harm suffered by Adam and Anna.

5.18 The failure to consider Adam's experiences or how the neglect had impacted on him is incredible, given the information provided by the school and knowledge that he had been living for 5 years in an '*unclean and unsafe home environment*' and alongside adults with significant offending history. Given the increased risk of IFCSA for those who are experiencing neglect it is deeply concerning that there was little or no consideration to the previous interventions under the Child Protection process in 2009 and no record that the children views were considered at all during the CiN meeting in February 2014 or seen by social care. Again, their voice wasn't presented to the CiN meeting in April 2014 other than a brief assertion that the home conditions (which were not described) may impact on Anna's physical wellbeing. The impact on both children's development was well documented by school staff and the health visitor, but appears not to have been collated in a manner that might have given a clearer picture of Adam and Anna's voice.

5.19 By July 2014, following the allocation of a new social worker, the views of the children were reported, but only in relation to the neglect. Again, the risk of IFCSA was not

[46] pg 10 Working together to safeguard children, 2018

[47] pg4 HM Government advice from practitioners worried about sexual abuse (2015). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf accessed on 28.07.18

properly addressed and no actions were allocated to ascertain their views or establish a safe way to explore whether either children were showing signs of suffering sexual harm, despite this having been recognised as a risk in 2009.

5.20 There is some evidence that attempts were made in August 2014 to ascertain Adam's views. He was spoken to on 20.08.14 but this was not alone and it was reported he kept looking at his dad and did not answer most of the time. There is no record as to why Adam was not seen alone. If this was requested and refused by his parents, this should have been noted as it was directly relevant to any assessment of risk of significant harm. He was observed to be 'grubby' with stains on his clothing. He was spoken to again on the 04.09.14 when he '*did not express any worries or concerns.*'[48] The ICPC minutes record his use of speech was very limited and that he could not tell the social worker what his daily routine was. It isn't made clear whether this was due to developmental delay or external pressures. Given the increased risk of IFCSA for children showing the level of neglect Adam and Anna were suffering, the lack of focus on securing their voice between October 2013-September 2014 was a substantial departure from expected practice which undoubtedly resulted in significant delay in beginning child protection processes.

5.21 CSC have confirmed they are currently in the process of developing a training offer regarding IFCSA for child protection staff, led by the Child Protection Advisor and Workforce Development manager using a resource developed by Research in Practice[49]. They are also hoping to develop a 'virtual team' drawing on support from the Children's Social Care Service Lead and liaison with Forensic CAMHS input to support CSC. Whilst this is to be welcomed, contributors to this review have asked whether it would be prudent to explore developing a fully multi-agency virtual team. Others identified current programmes for multi-agency training on the voice of the child[50] as good models to adopt.

5.22 As Allnock's research has shown, identifying and investigating for evidence of IFSCA is extremely complex and requires detailed understanding of the risk, possible presentations and legal considerations to ensure that evidence is gathered in a manner consistent with a fair process. Any training offer therefore needs to reflect this, it may also benefit from improvements to practice in detecting and disrupting other forms of child sexual exploitation. Frontline staff across health, education and social care must be supported to understand how best to record the justification for 'reasonable cause to suspect' and clearly set out the causal link to significant harm. In doing so they will find it easier to justify any protective measures are necessary and proportionate to detect and disrupt IFCSA even if they impact on the right to respect family life, as they protect against the absolute right of the child to grow up free from abuse. Articulating protection plans in this way should empower practitioners to challenge any non-compliance by the parent and act quickly to escalate matters when there is non-compliance. Any training offer must also provide practical guidance to ensure referral pathways for expert interventions are received and acted on in a timely manner.

Were the Child Protection Conference and Public Law Outline processes correctly followed and used effectively, if not, what were the barriers?

5.23 The initial response to the referral in October 2013 was inadequate for the reasons set out in pg 4.5-4.7 above. Whilst the lead social worker must have understood that there was reasonable cause to suspect Adam was at risk of significant harm because she commenced an assessment,[51] it does not appear that a strategy discussion or meeting took

[48] ICPC minutes, page 6

[49] https://www.rip.org.uk/resources/publications/practice-tools-and-guides/child-sexual-exploitation-practice-tool-2017-open-access/

[50] for example, the National Probation Service highlighted the Sand Art training offered by Hampshire Children Services

[51] in line with s47 Children Act 1989 duties

place. The practitioners who originally made the referral could not remember being asked to contribute to discussions at that time. Failure to do this was in breach of the LSCB policy as the policy requires that whenever there is reasonable cause to suspect a child is suffering significant harm) there is a strategy discussion with the police, health practitioners and school. Had such a discussion taken place, one must assume that in line with 'Working together' guidance[52] practitioners would have proactively shared information regarding the concerns arising because of the offending behaviours of adults within Adam's household.

5.24 Had the lead professional taken into account all information available to the local authority at that time and complied with the expectation to hold a strategy discussion it would have highlighted the risk of IFCSA and ensured those practitioners in almost daily contact with Adam and best placed to monitor his health and educational development were also alert to that risk. It would also, according to the LSCB policy, have necessitated the lead professional to convene an initial child protection conference within 15 days. Instead there was no effective action taken or support offered to address the risks which should have been very evident with even a cursory review of the case notes from 2009-10. CSC's quality assurance report gives no explanation for these failings and the lead practitioner from that period did not take part in the review. Educational staff felt it was indicative of services offered at that time and accepted they should have challenged and escalated concerns; they confirmed they would feel confident to do so in the future. CSC have reported improvements in practice, implemented since this time, in response to the findings of previous SCR reports.

5.25 The police were notified and included in strategy discussions in early August 2014 when a further s47 investigation commenced. This was processed by the police through Central Referral Unit and graded D for single agency progression as the principle focus was given as 'poor home conditions representing a potential risk/hazard to the children'. There is no record that police were asked to investigate a potential risk of IFCSA or to contribute towards an assessment of that risk, despite this being previously identified by CSC in 2009. Of course, the offending history was also known to that service and was later disclosed by them at the Initial Child Protection Conference, held in early September 2014. This was slightly outside the required timeframes (of 15 working days from the strategy discussion) but was not a substantial breach or significant delay.

5.26 In September 2014 legal services did not advise CSC to initiate proceedings under s31 Children Act, despite accepting there was justification for reasonable cause to suspect the children were suffering significant harm, because they were not satisfied that threshold for seeking an interim care order for immediate removal was met. At the time of this decision, legal services had reviewed information contained within a summary sheet, single assessment (dated 09.09.14), ICPC minutes and CP plan (from 09.09.14) and took the view that the risk arose principally from neglect and emotional abuse. During the practitioners meeting, it was acknowledged this would not have prevented them from starting the PLO pre-proceedings process. As noted in the SCR: Family A report, had such a structured assessment been carried out at this time, this could have led to earlier identification of sexual abuse and speedier intervention to provide protection to these children. Whilst assertions were given that the case would have had managerial oversight within legal services during monthly supervision if drawn to the attention of the supervisor by the allocated lawyer, there was no evidence of this. Legal services did confirm that improvements were made shortly after September 2014 to the LPM structure in order to improve practice.

5.27 In late April 2015 legal services confirmed there was sufficient grounds to initiate the PLO processes, but advised to commence at pre-proceedings stage as the parenting capacity assessment report had not been written up so Legal Services advised further

evidence would likely be required by the Court within proceedings under s31 Children Act 1989. By this time the social worker had completed risk assessments of PU and PGF, secured cognitive assessments of M and F and had evidenced a lack of engagement from M and F with numerous interventions already provided. There had also been a number of known incidence of unsupervised contact between the children and PU or PGF. She had also evidenced that both Adam and Anna were suffering developmental delay which was attributed to the level of care given. It is therefore not clear why a further 10-12 weeks was agreed for the lead social worker to complete the assessment report. PLO guidance required:

> *'All evidence and assessments on which the local authority intends to rely in support of its court application should be up-to-date and prepared in advance. Specialist reports must not be commissioned without the consent of the parents/carers. Where commissioned later in the process, the local authority should bear in mind their possible future use within proceedings, including the requirements of the court.* [Family Procedure Rules- Practice direction 25A]
> *Additional parenting capability assessment. Over and above those prepare as part of any statutory assessment, should be commissioned at the pre-proceedings stage where the local authority has a specific need for specialist expertise to enable it to reach its decision as to whether the threshold has been met and that proceedings would be the best way forward.'*[53]

If the previous assessment reports did not meet these standards this might explain why it was agreed to initiate the PLO process at 'pre-proceedings stage' rather than immediately commence proceedings. But it also highlights how the failure to apply PLO guidance and commence pre-proceedings processes in September 2014 was instrumental in this a 6-month delay. It is therefore surprising that CSC were not advised to accelerate their parenting assessment so that proceedings could commence at the 6-week review if insufficient progress had not been made.

5.28 It does not appear, from the information provided to this review, that clear instructions were given at the pre-proceedings meeting in May 2015 to the parents on the timescales for actions to reduce the risk of IFCSA or what preventative action the local authority would take to support Adam in particular understand this risk and report any concerns. Nor is there any clear contingency set out for what steps would be taken if the local authority became concerned that the parents were not complying with the contract. This was a requirement of the pre-proceedings PLO process in order to '*reduce the potential for delay, while also providing an opportunity to avoid proceedings*.' [54]

5.29 Practitioners from CSC and legal services expressed surprise that M and F appointed a joint legal representative. The PLO process did require '*where parents may not have capacity to engage full with the process, all efforts are made, such as working in partnership with adult services, to secure appropriate advocacy*'[55]. M's cognitive functioning had, by this time, been assessed and there was no reason to rebut the presumption[56] that M had capacity. Furthermore the 'protecting parenting', 'incredible years' and 'change sessions' had explored M and F's relationship and the impact their own childhood experiences had on their decision making. This was summarised within the Capacity to Care report which concluded M had '*a high ability to communicate her feelings and perceptions*

[53] pg 41-43 of 'Court Order and pre-proceedings' statutory guidance published by the Department for Education, April 2014 (accessed at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306282/Statutory_guidance_on_court_orders_and_pre-proceedings.pdf on the 30.07.18)
[54] see pg.34 ibid
[55] pg21 ibid
[56] set out in s.1 Mental Capacity Act 2005

well.' [57] There was no evidential basis therefore to intervene in her right to choose her legal representative

5.30 Practitioners did voice concerns at the next RCPC (a few days after the PLO meeting) about the parents' ability to protect the children given their non-adherence to the contract. Again the minutes of that meeting do not specify how this could impact on the risk that the children might suffer sexual abuse and this is not recorded as a risk category. Nor does failure to adhere to the contract prompt escalation to seek the initiation of proceedings despite the length of time parents had been supported to implement a change in their ability to care safely for the children and protect them from a perceived risk.

5.31 A police representative was in attendance at this RCPC and did confirm checks of the family's offending behaviours had been undertaken. This was notable because, with the exception of the RCPC on the 15.03.16, police did not attend any other RCPC. This was in line with the agreed local protocol and internal operational practices. As part of this review, police staff estimated Hampshire Constabulary receives approximately 130 requests to attend 'building better relationships' and safeguarding meetings for children or adults at risk of abuse or neglect each week. These are initially considered by a specialist 'Safeguarding Staff manager' and all requests for attendance at an Initial Child Protection Conferences are allocated to either the investigating officer (if subject to a live criminal investigation) or to 1 of 8 'Conference Attenders'. Conference Attenders are police staff who have received specialist safeguarding training to be able to assess and analyse risk. Where there is an ongoing crime investigation, that officer in the case will continue to attend all subsequent RCPCs where required. If there is no ongoing criminal investigation, requests for attendance at a RCPC will be passed to a safeguarding coordinator who review all police records and provide any update or, if they believe necessary, request a Conference Attender be present. The safeguarding coordinators are not of sufficient rank to review and analyse risk, but do have access to supervision and can escalate or ask advice from the Safeguarding Staff Manager whenever necessary.

5.32 The police explained, where police are present within a conference and it is identified that agreements are not being adhered to and that failure places children at further risk, it is usual practice that the Conference Attender creates an intelligence log and submits it for further development (e.g. notifying other departments such as CAIT, Safeguarding and Offender Management or the MASH). Where further risk is identified from the conference and police are aware, a PPN1 form would be completed to capture risk. This is subject to further scrutiny, assessment and grading within the MASH. They also commented that non-attendance at a RCPC would not prevent them assisting outside this formal meeting as there is an expectation that a CP Conference Chair would revert for further advice if fresh information or concerns suggested it would be necessary. The police confirmed it was 'normal practice' to conduct a joint visit if information was shared at a conference that required further investigation. There is no evidence within any of the RCPC minutes that police were asked to attend and failed to do so or that they were asked, in response to non-compliance with supervised contact, to carry out a joint visit.

5.33 Police staff advised this review that normal operational procedure would be for non-adherence to any element of a child protection plan to be escalated internally within CSC and legal advice obtained with a view to the Local Authority securing legal powers to intervene under s.31 Children Act 1989. Whilst it is accepted that for most categories of risk this should be the procedure, it must be recognised that the nature of IFCSA and particularly where it is associated with high levels of neglect, involving police officers (via MASH) in assessments of risk could enable earlier detection of any criminal activity, or act as a deterrent/preventative factor. It is possible, even taking into account Adam's reported

[57] section 7.6 Capacity to Care report

discomfort around police, that attendance by the police at the family home could have been justified and that questioning by them of PU, PGF, the parents or indeed the children on each occasion that unsupervised contact was reported during 2015-16 might have provided 'reasonable cause' or, alternatively add an additional external inhibition to IFCSA.

5.34 Given the complexity of detecting IFCSA it might be prudent for CP chairs to actively consider requesting input from police or other professionals with specialist expertise in sexual abuse so that protection plans more carefully articulate concerns regarding IFCSA and set out clear examples when it would be justifiable to refer for further police engagement or criminal investigation. The offending behaviours of adults in the home was not contextualised in a way that staff believed would happen now. The establishment of Police Safeguarding Conference Attenders has, it was reported, improved consistency and the quality of information over that which might have existed in 2014-16. There are opportunities for Attenders to meet confidentially with the lead social worker and Conference Chair before a review meeting to contextualise any new information, review risk and aid in the assessment of information. From June 2018 the Conference Attender will also remain behind after the conference to provide context and further risk assess. They are also required to record a summary of any discussions on police electronic records and log any safeguarding activity that has been agreed. If necessary this might include a PPN1 to be submitted to the MASH for assessment and grading.

5.35 Throughout this period the contract of expectation remained unsigned and insufficient weight appeared to be given (within both the PLO and CP processes) to parental non-compliance with this action. Legal services wrote to the parents' solicitor, but without specific reference to the risk this failure posed to the children suffering sexual abuse. Practitioners (during the professionals meeting for this review) commented that the parents' behaviour during this period became notably more obstructive, picking through every aspect of the contract. Whilst there is evidence to support that was the case, it makes it all the more surprising that this change in behaviours (coupled with the conclusion by the SAT assessment and Capacity to Care report) did not trigger a request for an earlier RCPC despite the significant change in the understanding of the lead social worker and an intention to significantly change direction of the child protection plan by initiating proceedings. There is, however, no breach of the CP process; that only requires that review conferences are held at a minimum of 6 months. Of course, RCPC can be held more frequently (as was expected to occur in this case in the latter half of 2016), but there is no expectation that a review is undertaken if evidence concludes prior to the six-month period, that a significant change to the protection plan is required.

5.36 The lead social worker did try to progress this case through the PLO processes and had arranged for a further legal planning meeting on the 20.08.15 to request the case move into proceedings. For the reasons set out above that meeting did not occur. The lead social worker also reported requesting support at team manager and principal social worker level to ensure the case was escalated and that proceedings commenced. The outgoing lead social worker reported having discussions with the core group attendees advising them of the outcome and main findings of the Capacity to Care assessment in order to protect against any de-escalation. But in her absence this was not reported to the RCPC chair. Legal services did subsequently make attempts to progress legal proceedings,[58] but did not escalate the lack of response beyond CSC team manager level. Partners may wish to reflect on whether, if expected levels of managerial oversight had occurred, this could have improved continuity regarding the level of risk and resulted in proceedings that would have protected the children. CSC have reported that staffing structures and tracking mechanisms have been improved since this time to protect against drift in cases or failure to escalate. Nevertheless, it is crucial to ensure that the current risk profile and protection plan is

[58] detailed in pg4.30 of this report

understood and agreed by those working most closely to support children. Had there been a RCPC at this time it would have been clear to the parents and all practitioners involved that the threshold for initiating child protection proceedings had been met and consequently, even given the subsequent change in lead social worker, unlikely that the clearest opportunity to protect Adam and Anna would have been lost.

5.37 The level of factual inaccuracies recorded within the minutes of Review Child Protection Conferences, e.g. in October 2015 as detailed at pg 4.26 and the lack of challenge regarding drift suggests the conference Chair wasn't always able to prepare fully so that they knew the case. It wasn't until the following RCPC (in March 2016) that a new Chair questioned the length of time the children had been subject to CP and PLO processes. Within the meeting there isn't detailed discussion regarding the risk of IFCSA.[59] This ongoing risk is recognised within the Chair's summary, but there is no action within the CP plan to address this other than a very generic '*parents to continue to adhere to the contract… social worker to implement this*.'

5.38 During conversations as part of this review, practitioners reported their frustration at the lack of powers they had to explore or monitor contact with external family members. They reported that they knew that some contact did continue, but had been assured by both parents that this was supervised. One gets a sense that practitioners felt they had little option in the absence of absolute, irrefutable proof to the contrary but to assume that all contact will be supervised on visits to the former family home. Whereas a full analysis, (based on the facts as known and taking into account whether, on the balance of probabilities, the parents were adhering to the contract) may have justified seeking agreement to test this through direct work with the children. It may also have triggered a request for advice and support from partner agencies with expertise in offending behaviours or forensic sexual abuse risk assessment and more careful exploration of any additional disruption mechanisms which could have been employed to prevent IFCSA from occurring.

5.39 There is evidence that practitioners undertook detailed consideration of the previous capacity to care assessment and weighed improvements to home conditions against the children's presentation and developmental progress. The Chair's assertion that '*a long period of further child protection is not an option'* was also misunderstood. In conversations as part of this review, the Chair confirmed this was in recognition of the apparent drift in this case and because she felt there was sufficient evidence of long-standing neglect adversely impacting on the children's development to initiate proceedings. A number of practitioners later reported they had interpreted the Chair's comments as suggesting that the case could be de-escalated, but again no-one sought clarification from the Chair. It was unanimously agreed that a further short period (3 months) was needed and the social worker was tasked with completing an addendum report on the parents' capacity to care.

5.40 The RCPC was rescheduled and did not take place until July, despite a prompt review having been a core part of the previous plan. By August the Addendum Capacity to Care report had been completed and there is evidence that this clearly informed risk analysis and decision making at the Conference [see pg 4.36]. During conversations as part of this review, the legal team and social worker remembered speaking with each other regarding the findings within this assessment. They both commented that the changes in way the parents engaged with practitioners were remarkable, given their earlier resistance. They reported feeling 'uncomfortable' that the evidential burden for removal of the children was no longer present due to the length of time the parents had sustained improvements to the home and an inability to demonstrate that they had not adhered to the need for

[59] It was noted within the 'complication factors' section that it was '*unclear if* [Adam and Anna's] *contact with their extended family is supervised although there is no evidence to suggest that it is not as the parents say that it is. However, as the parent's do not recognise that this is a risk it is unsure as to whether they will adhere to their agreement with social services.'*

supervised contact. Practitioners were clear that, despite other improvements, they remained alert to the risk of IFCSA and were all aware of the need to report any non-adherence to this or any presentations/ behaviours by Adam or Anna that might indicate they were suffering sexual abuse.

5.41 Practitioners, including legal advisors, appeared to have approached their duties to adhere to the PLO and CP processes as one that required linear progression. This was evident from the beginning of the review period. The first intervention commenced at CiN level despite sufficient evidence that the threshold for investigation under child protection was met. It then proceeded onto Child Protection planning, by September 2014 when there was sufficient evidence to require the initiation of the PLO process. Delay in commencing that meant that practitioners seemed to assume they must then carry out a period of pre-proceedings assessment. The unacceptable drift, lack of any case specific risk analysis and application of that to the thresholds for commencing legal proceedings under the PLO processes went largely unchallenged as did F and M's assertions that practitioners concerns were unwarranted.

Were risk assessments informed by further disclosures and non-adherence to the protection plan?

5.42 Throughout this case there are numerous examples of practitioners collating further information pertinent to the parent's ability to understand the risk of IFCSA and act to protect Adam and Anna from harm. For example, careful records were kept and information shared when F disclosed he had been emotionally and physically abused by his mother and that wider family members had suffered IFCSA. The social workers also reported having 'difficult conversations' with F regarding his views on IFCSA and reported all discussions regarding the potential harm PU or PGF may pose, e.g. in April 2016 when F commented he '*couldn't be sure PU were innocent'*. These provided very useful indicators to his understanding of the nature of trauma sexual abuse causes and of his ability to protect. On the face of the documentary evidence submitted to the review, it does not appear this was used to review or update a risk assessment so as to establish at the earliest possibility whether, on the balance of probability, the parents had capacity to protect the children from what was perceived as a risk by practitioners. F and M's unwillingness/ inability to accept practitioners' conclusions that there was 'reasonable cause to suspect' was never fully explored, nor was sufficient weight attributed to this when weighing up whether they would be a protective factor against this risk.

5.43 In his 2003 report into the death of Victoria Climbié, Lord Laming[60] stated:

> "*I recognise that those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task...Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the wellbeing of a child."*

Practitioners must therefore be empowered to very clearly set out the responsibilities of parents/carers to engage fully with protection plans to detect and disrupt activity irrespective of how skeptical the parent might be of the risk. Where there is skepticism, practitioners should be confident to justify findings and decisions in accordance with public law principles[61] and according to their own professional standards; thereafter, parents/carers

[60] Victoria Climbié Inquiry, the Lord Laming Report, 2003:3
[61] *R(AB and CD) v Haringey London Borough Council* [2013] EWHC 416 (Admin)

should also be informed of their available options if they wished to formally challenge a decision. Failing a successful challenge, practitioners should be clear with parents that any failing to adhere to the protect plan will almost always require escalation into child protection proceedings.

5.44 During the review period, there was no obvious evidence of frequent reviews of the risk analysis regarding IFSCA, despite this being the core purpose of the RCPC process. Instead this appeared to be subsumed into lengthy assessment documents, such as the Capacity to Care report. Unfortunately, this probably made it more difficult to hold F and M to account for their failures to protect the children, partly due to the lack of parental engagement with the CP process and also the frequent changes of personnel in core positions of responsibility (such as the Chair and lead practitioner). This is demonstrated by the failure to correct factual inaccuracies reported to the RCPC in October 2015. The RCPC minutes should have actively reviewed the level of each type of identified risk and updated each to reflect long delays in both M and F signing the contract due to resistance to accept the terms, clear breaches on at least 5 separate occasions and frank disclosures by both parents that they did not believe PU or PGF posed any such risk.

5.45 The social worker, within supervision in August 2015, highlighted to her manager that she believed the children were regularly left unsupervised with PU and PGF but was finding it difficult to prove. There is no evidence that she was provided with any guidance or encouraged to seek legal advice or support from other agencies with expertise in investigations into sexual abuse or offender management. Whilst there is evidence of regular communication from the social worker to the legal team, it does not appear that she receives advice on how to progress or escalate the case, given her concerns that the children are left unsupervised and therefore she had reason to believe they could be at risk of significant harm.

5.46 It is remarkable that the risk of IFCSA was not specified explicitly within any of the CP plans and never identified as a category of risk. Practitioners working alongside CSC reported they hadn't fully appreciated that CSC believed PU and PGF posed an ongoing risk of IFCSA. The police, health visitor or school staff didn't contribute to PU or PGF's risk assessment directly and were not provided with copies of those. They reported understanding that the allegations were historical, but accepted they knew the rationale for regular scheduled and unscheduled visits was to monitor compliance with all aspects of the contract of expectations, including ensuring that there was no unsupervised contact between the children and PU or PGF. Furthermore, all practitioners knew to report any breaches of unsupervised contact with PU or PGF at the earliest opportunity and there is evidence within the chronology that they did so. Practitioners reported a sense of frustration that they worked well together to ensure unsupervised contact didn't happen outside of the family home, but reported feeling powerless to protect Adam and Anna from any potential risk within the family home when faced with assurances from their parents that they were supervising all contact even after they moved away from the home they had shared with PU and PGF.

5.47 It must be noted that, throughout the review period there was insufficient evidence available to practitioners to unequivocally prove that PU was sexually abusing Adam and Anna, though of course it is now known from PU admissions within the criminal prosecution that this occurred on a frequent basis both before they moved from the address shared with PU and after. Throughout this period both F and M gave clear assurances that all contact would be supervised. For example, in May 2016 that M confirmed to the social worker that whilst she "*might not agree*" with the Local Authority's view that the children are supervised (whilst visiting PU and PGF), but she would continue to do so once the Local Authority are no longer involved as it "*keeps her mind at ease"*. There was, as documented above, almost a complete absence of challenge to those assertions. There was also too much reliance

placed on practitioners' responsibilities to detect and disrupt any possible IFCSA. The only mechanism designed to reduce this risk was the requirement for supervised contact.

5.48 Neither M and F were requested to report any concerns they may have or instructed on what to look for as signs that Adam or Anna might be at risk of IFCSA. Practitioners had already identified they would be unlikely to do so, given their stated position that professionals suspicions were unjustified. But, nevertheless, it is crucial for practitioners to remember this is a shared risk management plan and that, whilst children remain in the care of their parents, some onus must be on the parent to pro-actively protect their child. Allnock justified her reports' focus on the vulnerabilities that increased the risk of IFCSA for children who also experience neglect on the basis that it was those factors that practitioners might have the most opportunities to address. She equally warned against focusing exclusively on those factors at the expense of other contributors to the problem, the most obvious of which would be the perpetrator's responsibility. Of course, a balanced approach is needed to avoid stigmatising a non abusing parent, but this is best done in the context that the parent is made fully aware of the nature and level of risk and understands practitioners' views on what steps would be expected of a 'reasonable parent' to protect against that risk.

5.49 It is understandable that most would not think it should be necessary to encourage a parent to be curious when faced by risks that their child might be exposed to sexual abuse, but studies indicate that families react more negatively to disclosure of abuse when this is perpetrated within the family that when the source is external. The types of negative and adverse disclosure reported by adult survivors includes disbelief, blame, minimization of the abuse, ignoring the disclosure, accusing the victim of lying or otherwise punishing the victim, parental rejection, neglect, indifference, anger and avoiding talking about the abuse or listening to the victim.[62] Given that context, it is important that practitioners place significant emphasis on parental responsibility to safeguard.

5.50 If M and F had been told they needed to be vigilant and had been encouraged to exercise curiosity or understood the legal ramifications for them if they did not report signs that indicated Adam or Anna were at increased risk, one can only speculate now whether this would have led to them being more pro-active. It is now known that evidence of the abuse had been stored by PU onto M's computer. At that time, neither the police or CSC had legal powers to search for such evidence because the standards of proof for such searches were not met. However, it would've been lawful for M to have reviewed those files. She reported that she did not do so until after PU's arrest. It is important therefore that parents are not only vigilant and pro-active in identifying possible indicators of abuse with regard to the interactions between their children and family members; they must also be encouraged to have regard to the possible indicators of all four dynamics of sexual abuse, including perpetrator behaviours.

5.51 Given the similarities previously identified between this case and the findings in Child M and Child L SCR (published in 2014) and reports by staff of the parents frequently aggressive, domineering and manipulative behaviours it is also important to consider whether vicarious trauma was a barrier in this case. Research[63] has identified the effect that working with traumatized children and families has on social workers and how this might impact on individual cases and organisations. Both local policies and working together guidance required that social workers working in child protection are supported through effective supervision arrangements. As set out above, there is little evidence that supervisory support was provided in line with LSCB guidelines, despite this being a complex case where staff had reported open aggression from F and M to their involvement. Since this

[62] see Debra Allnock's research report at p12 and p24, ibid

[63] summarised in a NSPCC report (dated August 2013) available at: https://www.nspcc.org.uk/globalassets/documents/information-service/research-briefing-vicarious-trauma-consequences-working-with-abuse.pdf and accessed on the 26.07.18

time, CSC have restructured their service to ensure improved oversight of child protection cases. Whilst these changes are welcomed, for these measures to be effective in improving practice, operational frontline staff and their managers must engage fully with CSC Quality Assurance unit and build confidence to discuss challenging cases and report on all organisational or inter-agency barriers so that these can be quickly addressed at strategic level.

Was the voice of the child given sufficient weight within the child protection process?

5.52 The impact for Adam and Anna of the sexual abuse they had to endure is documented above within section 3. That they suffered significant harm is beyond dispute, having been determined by the Family Court in subsequent proceedings. However, further assessments undertaken as part of those proceedings indicate that both M and F still had not fully understood the unique nature of the trauma caused by this type of abuse.[64] It is important therefore to reinforce how crucially important it is that practitioners are aware of and confident to articulate to family networks the impact for children exposed to this type of harm. Whilst the level may vary in each individual case, the Traumagenic Dynamics Model[65] suggest four trauma responses following child sexual abuse, namely:

- Traumatic sexualisation: where sexuality, sexual feelings and attitudes develop inappropriately or dysfunctionally;
- A sense of betrayal: as the harm was caused by a trusted person;
- Powerlessness: because their will was repeated contravened
- Stigmatisation: where shame and guilt are reinforced and become part of the child's self-image

5.53 Traumatic sexualisation may underpin a subsequent emergence of harmful sexual behaviours for some victims and, whilst these behaviours will not always occur, professionals supporting Adam and Anna's recovery were clear that they and their carers will need continued access to specialist therapeutic interventions throughout their childhood, adolescence and adult life in order to minimise the risk of harmful sexual behaviours emerging and support their social and emotional development. There is also increased risk that a child who, because of previous sexual abuse, exhibits sexualised behaviours might experience negative responses from the wider community causing further stigma which have important psychological and physical health consequences. Studies show children who have experienced sexual abuse at increased risk of post-traumatic stress disorder, borderline personality disorders and behavioural problems, placing further strain on the child and parent/carer relationship.

5.54 Throughout this review process there has been a commitment from practitioners involved in the case to ensuring that lessons could be learned and applied in future practice; it was also very clear that each agency fully appreciated that safeguarding is a core responsibility within their own organisation. However, it must be acknowledged that practitioners from different agencies have their own specific, separate focus and that this can sometimes mean that there isn't a common language or shared understanding of risk. Within this case, for example, practitioners felt they had set out the risk of IFCSA and demonstrated Adam and Anna had presented some signs of trauma, yet colleagues within legal services were not confident that, on the information available, there was justification to escalate into civil proceedings without more concrete information to demonstrate they had suffered IFCSA. For this reason, it is important (even if many will feel this should be self evident) to highlight the importance of ensuring the voice of the child is central to every decision, including a decision not to act.

[64] Dr. Lockmuller's assessment, dated 25.11.17
[65] Finkelhor and Brown (1985) and Hackett and colleagues (2015) reported within Allnock's paper, ibid

5.55 Reporting information in a format which gives prominence to the 'voice of the child' is not merely best practice, but a fundamental legal obligation. It affords practitioners an opportunity to frame their observations and why those observations are important (given their specific expertise) into a common language underpinned by the obligations set out in the Human Rights Act and UN Convention Rights of the Child ['UNCRC']. Understanding how these fundamental legal principles should be applied in practice will assist practitioners to ensure that their contribution to the shared understanding of risk is valued and, importantly, understood. All practitioners working within public bodies are required to balance the sometimes seemingly conflicting freedoms protected by the Human Rights Act. Similarly, any statutory obligation must be enacted in a way that upholds the UNCRC, including article 12 (respecting the views of the child), article 18 (parents and carers responsibilities to ensure they consider what is best for the child) and articles which require adults to work with government agencies to enact all the rights protected by the Convention, including protecting them from all forms of sexual exploitation (article 34). Early recognition within child protection processes that these standards form the basis of the welfare principle within s1 Children Act should empower practitioners from whatever discipline to challenge whenever care and support falls below expectations and frame that failure to demonstrate the implications for the child's best interests in a way that will resonate with the judicial system.

5.56 Practitioners from across the partnership understood their duty to safeguard in this case, for many this meant recognising, responding and reporting the risk of IFSCA and any non-compliance with the protection plan. There is evidence that this level of input was received. For the local authority and police this required that they used all legal powers available to prevent abuse and, bring the perpetrator to justice and support the children recover.

5.57 As the cohort of practitioners involved in safeguarding investigations and protection plans expands so too does the legal frameworks that govern each agency. Whilst this brings increased opportunities it can also lead to unintentional barriers developing, increasing the chances that these will be exploited by perpetrators, e.g. any lack of clarity regarding referral pathways or thresholds for support from statutory agencies. On the evidence provided within this review, it is clear that attempts were made to represent the children's wishes. For example, very careful consideration was given to the natural affection the children frequently showed their parents; it was also clear that practitioners understood they would need very cogent reasons for seeking to intervene in family life. Both Capacity to Care reports were very detailed and clearly gave careful consideration of the welfare principle particularly when balancing the natural affection displayed against the very obvious signs of developmental delay caused by the long-standing neglect and the more obscured harm caused by the risk of IFCSA. The minutes from the RCPC were, understandably more concise than the assessment reports but also appeared on occasion to place greater emphasis on enabling M and F to voice their views and challenge practitioners' views. Of course it is a fundamental principle that parties must have such opportunities and the value placed on this is best demonstrated by its inclusion within the Human Rights Act (article 6) and professional practice standards for police, social care and the legal profession. But crucially practitioners must remain at all times child-centred in order to reduce opportunities that manipulation of circumstances or the facts might drown out the voice of the child.

5.58 Practitioners must be alert, particularly given the specific risks associated with IFCSA to such manipulation. In this case there was some evidence that Adam and Anna were seen, but rarely were they spoken to alone. Case notes and assessment reports demonstrate some evidence of direct work being undertaken with Adam and Anna during the period under review, but often their voices are not recorded or were stifled by parental views. Psychological assessments identified that F needed to be in control of environment and practitioners reported that he was very physically intimidating to staff. It does appear that

practitioners within the RCPC meetings were dominated by F's views and found it difficult to challenge his dismissal of their concerns. Staff from Adam's school reported that the extent of his developmental delay and questions as to whether this was organic in nature or a consequence of the neglect he had endured placed very real practical barriers to fully understanding the nature and extent of abuse he was suffering.

5.59 Securing the voice of the child must be used as a mechanism for all those involved in providing care to reflect very carefully on the underlying purpose of all relevant legal powers and responsibilities that underpin child protection. The Children Act was designed and must be interpreted to ensure the rights enshrined in the Human Rights Act and UNCRC are protected. Social workers and therapists involved in his recovery reported that Adam was a child who was very guarded and scared to give any information to social work practitioners, yet there was little consideration given to seeking input from specialist behavioural therapists or even support school staff (within whom he had developed a rapport) to undertake work with him that might have increased his opportunities to disclose the abuse he was suffering. Where direct work was undertaken practitioners reported that they placed significant weight on this. For example, practitioners believed they had clearer reported that Adam's 'dream home' (drawn in March 2015) was very insightful and indicative of a child suffering significant trauma. However, even if that message was clearly understood by CSC's legal advisers, they report it may have proved difficult to present this in a manner that would have satisfied the evidential burden imposed by the Family Court. Nor was the information shared with police colleagues to enable a reassessment of risk posed by PU/PGF or a request made to police for further assistance with the safeguarding investigation. Focusing on how the child's presentation, developmental progress and all other environmental or risk factors might impede on their fundamental rights can only improve a shared understanding of risk and thereby enable practitioners to better evaluate how best to use available legal powers to act to protect.

Recommendations:

Training:

1. The LSCB set up a task and finish group and/or host a practitioners' workshop to explore whether protocols for increased inter-agency work or joint training could be developed to respond to a perceived risk of inter familial child sexual abuse. The focus should be to develop a shared understanding of the legal framework and empower practitioners across partner agencies by providing clarity on:
   - the full victimisation profiles of children at risk of neglect and IFCSA in order to address the cumulative impacts of harm;
   - the legal powers that could be employed when supporting families to ensure that perpetrators find fewer opportunities to target and abuse children. [pg 1.13 and 5.34]
   - the services available locally to support children, families and practitioners (including school and health staff) working with children who are at risk of IFSCA recognise and report such abuse [pg 5.22];
   - the role of parents in protecting children at risk of IFSCA [pg 5.50]
   - legal powers and expectations when collating and sharing information so as to assist lead agencies (social care, the police and CPS) to progress matters into Court in a timely manner. [pg 5.4]
   - the evidential burden required to arrest for offences that might arise where there is neglect and a risk of IFSCA, including complicity offences, so that a child is supported through specialist interview techniques and any criminal investigation can commence at the earliest opportunity. [pg 5.34]

2. The LSCB seeks assurance that staff from relevant agencies, including designated safeguarding leads within schools, school nursing staff and health visitors, receive learning from this review and the LSCB give consideration to how to measure the impact of that training, e.g. review of referral data, audit or professional surveys. Any training offer should include guidance on retention of records, compliant with GDPR, Data Protection and Freedom of Information obligations. [pg 4.11]

Pathways and Processes

3. Where there is reasonable cause to suspect IFCSA may occur, this must be recorded as the principle category of risk and evidence of other types of abuse carefully considered against the Finkelhor's four preconditions model so that plans and contingency plans adequately reduce risk through early detection or disruption as with other forms of child sexual exploitation. [pg5.15]

4. LSCB to explore opportunities for Child Protection Conference Chairs to secure advice from agencies with expertise in management of offending behaviours on the possible risk reduction measures they can lawfully employ as part of a CP plan and when failure to comply with any protective measures could indication reasonable grounds to believe a child may be experiencing significant harm. [pg4.27]

5. LSCB give consideration to reviewing multi-agency guidance so as to clearly indicate that CP and PLO processes are not linear, but require exercise of professional judgment having regard to the thresholds set out in legislation. This should also make explicit that it is expected practice that a RCPC is held whenever there is a significant change in the protection plan, including a conclusion by the lead practitioners that proceedings should commence. [pg5.36]

Quality Assurance

6. LSCB review mechanisms used for securing assurance from all member agencies that they:
    - actively implemented supervision within practice including how the escalation policy works within agencies. [pg4.12]
    - effective processes of case reallocation / handover when active risks are being managed [pg4.25] or when the child[ren] have been subject to a CiN or Child Protection process previously [pg4.9].
    - pathways are widely understood and that any practitioner who believes there is reasonable cause to suspect a child could be at risk of IFCSA raises this in line with the referral mechanism through MASH

7. LSCB to seek information on commissioned therapeutic support/services locally to work with perpetrators and cascade details of referral pathways to the multi-agency. [pg5.12]

8. LSCB to seek assurance from NHS England and/or the CCG regarding support services for children and young people who have experienced IFCSA. LSCB to seek assurance that the access to therapeutic services is included and monitored as part of the children's LAC planning. [p5.53]

Supervision and management oversight

9. The relevant lead person from CSC provide assurance that oversight of assessment process and decision making is robustly monitored by team managers. Also that service managers have oversight of decision making trends and that decisions are 'dip sampled' as part of the service Quality Assurance processes. [pg4.9] Focus must be given to:
    - those child/ren who have been subject to a CiN or Child Protection process previously.
    - Where there is reasonable cause to suspect IFCSA is a risk; or
    - continuity of practice- especially when an outgoing lead professional believes there are reasonable grounds to believe a child is at risk of significant harm to ensure managerial oversight is consistent. [pg4.25]

Appendix 1: Agencies involved and documents made available to the review

In undertaking this review I have considered the following relevant policy documents:

- Working together to safeguard children, published 2013
- LSCB pan Hampshire child protection policy and procedures. current local protocol was published in August 2015 (available at: http://southamptonlscb.co.uk/wp-content/uploads/2012/10/Southampton-City-Council-Protocol-for-Childrens-Social-Care-Assessment1.pdf). This would not have been available to staff practising in October 2013, but was devised to recognise expectations set out in national guidance, namely 'working together to Safeguard Children' 2013.
- Principles and Standards for Safeguarding Supervision, dated 16.01.15

I have considered Debra Allnock's research 'Exploring the relationship between neglect and adult-perpetrated intra-familial child sexual abuse, Brook sexual behaviours traffic light tools and NSPCC's research into vicarious trauma.

I have considered previously published SCR reports, notably:

- SCR: Child I & M, Jane Wonnacott (2014) available at: http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2014SouthamptonChildIChildMOverview.pdf?filename=CC18C70DB7C8C3D49403BB94EB176F95207E5F66235DCA89651F5ED2BA7D89311A353B626FC61241A3DF9A45C356BB4E0BBCC55A4C64218696DD1C6D27E9133A738D7A86340A9C25B210AA9A1B84E36E106AA50A7A93E984C73AC2C8C0AC086619FD52E3DED6017F&DataSetName=LIVEDATA
- SCR: Child L, Moira Murray (2014) available at: http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2014SouthamptonChildLOverview.pdf?filename=CC18C70DB7C8C3D49403BB94EB176F95207E5F66235DCA89651F5ED2BA7D89311A353B626FC61241A3DF9A45C356BB4E0BBCC55A4C64218696DD1C6D27EC1F247F9368A21E0BD727A01FF09690AD6FAA615F90F904A702E48A0360870ED92703DFF6&DataSetName=LIVEDATA
- SCR: Family A, Kevin Harrington (2014) available at: http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2014SouthamptonFamilyAOverview.pdf?filename=CC18C70DB7C8C3D49403BB94EB176F95207E5F66235DCA89651F5ED2BA7D89311A353B626FC61241A3DF9A45C356BB4E0BBCC55A4C64218693D418682FD9111D6C846CBD12198E79B41DA9F09EB105E033EF04CD488C346415A8E963BFFC57B40C13C3&DataSetName=LIVEDATA

The review was also informed by meetings with two of the Child Protection Conference Chairs involved in the case, two of the lead social workers, the Designated safeguarding leads and head teacher from Adam's schools, the health visitor, school nurse and legal services. I also reviewed the quality assurance reviews undertaken by Southampton City council's children social care and legal services department and detailed summaries of case records and chronologies from:

- Southampton City Council's Children Social Care
- Southampton City Council's Legal department
- Southampton City Council's Housing department
- Hampshire Constabulary
- Solent NHS Trust who provided health visiting and the school nursing services
- South Central Ambulance Service
- Southampton City Clinical Commissioning Group - Primary Care

Additional information, in response to specific queries, were received from:

- Southampton City Council's Children Social Care
- The GP where M, Adam and Anna were registered during this period. Noted that F, PU and PGF were registered at another practice.

- The Health Visitor
- Hampshire Constabulary

The following case records, and assessment reports were reviewed:

- Minutes from Children in Need meetings dated 24.04.14, 05.06.14, 18.07.14, 28.08.14 and, following de-escalation from CP process 19.08.16, 27.09.16
- Minutes of ICPC (dated 09.09.14) and RCPC dated 26.11.14, 08.05.15, 22.10.15, 15.03.16 and 17.08.16
- Case note reports of home visits on 16.12.14, 19.12.14, 20.12.14, 03.08.15 and 04.08.15
- Supervision reports of 14.01.15 and 17.08.15
- Risk assessments of PU and PGF re IFCSA
- Contract of expectations
- Capacity to Care report and Addendum
- Specialist Assessment Team intervention plan and report
- Court bundle, including psychological report of M and F prepared for the subsequent care proceedings
- Sibling Together or Apart Assessment

Appendix 2: Biography of the Reviewer

Fiona Bateman, a solicitor specialising in public law, is an experienced litigator and has expert knowledge of health and social care law and safeguarding responsibilities having advising local authorities since 2003. In this role she has contributed to key project work advising the implementation of multi-agency joint working agreements for integrated health and social care provision and was recognised for innovation as a finalist for the Young Lawyer of the Year in 2013.

She has worked as an Independent Chair to Safeguarding Adults Boards since January 2014 and is an active member of the Regional SAB and Chairs' network. She also has experience in commissioning, writing and chairing safeguarding learning reviews (SAR/SCR) in line with the 'Learning Together' and other review models. In 2017 she contributed to RiPfa's '*Safeguarding Adults under the Care Act 2014*'.

She has designed and delivered legal framework training programmes since 2006 to delegates from public, private and voluntary sectors on a wide range of topics including Social care responsibilities, Safeguarding, NHS Continuing Healthcare, Housing, Immigration, Data Protection, Mental Capacity Act and Deprivation of Liberty Safeguards, the Human Rights Act and Equality Act obligations.