Local Child Safeguarding Practice Review

Executive Summary

Family H

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November 2023

Introduction

Darlington Safeguarding Partnership has published a Local Child Safeguarding Practice Review (LCSPR) report for Family H following evidence of child sexual abuse.

Working Together to Safeguard Children 2018 statutory guidance sets out the process for Local Child Safeguarding Practice Reviews. Darlington Safeguarding Partnership conducted a Rapid Review, and it was decided that a LCSPR was appropriate. The Partnership appointed two review authors to lead the review. The purpose of the review was to look at how multi-agency services worked together to safeguard the Family H children.

The review has been undertaken using a hybrid systems approach and significant incident learning process (SILP) methodology. This process engages front line staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time, avoiding hindsight bias and individual blame. Opportunities for improvement within systems for safeguarding children are identified and strengths promoted.

The review considered agency involvement from January 2013 to January 2023. Whilst Family H was not open to statutory authority, there had been multi-agency involvement and a number of referrals to Children's Social Care during the period of review.

Story of the children and family

Family H consists of 4 children under the age of 16. The family is white British, father originates from local area and mother originated from outside of local area with minimal support from her own family. Parents often struggled to cope with four children and paternal grandmother provided a high level of support to the family. Children were presented as happy and content and well dressed and interacted well. The two eldest children had some health issues and assessments which identified speech and language and developmental delays. The younger siblings were generally healthy.

In April 2022, the children's aunt and her partner were arrested due to suspected sexual offences against children and their devices were seized. Examination of the devices found indecent images of children and further enquiries led the police to believe that the Family H children were also victims of sexual abuse.

The review focussed on a number of key episodes over a ten-year period. In 2013 parents agreed to abide by a written agreement which stated aunt and her partner should have no unsupervised contact with their children due to aunt having her own children removed and being in a relationship with a partner who has previous sexual offences against children and potentially remained a risk.

The review found examples of good practice and looked at how services had worked together to protect the Family H children, the following key themes were identified:

Key Learning

- **Professional curiosity and challenge** – whilst there were some good examples of professional curiosity there are several instances where this could have been improved. Some agencies were considering the link between the children's behaviour and the possibility of sexual harm, however there was a lack of professional curiosity and challenge leading to missed opportunities to identify the risk. The risks to many children are not always obvious and require continuous professional curiosity about the child and their circumstances. Practitioners need to understand what is happening within a family rather than making assumptions or taking things at face value and remain sceptical of explanations, justifications or excuses and 'check out' what is being said.

- **Assessment of risk** – the risks posed by the adults were never fully explored and understood by agencies involved with the family and the risk assessment was not applied to any of the work undertaken in the early intervention framework. Some agencies held information regarding the risks, however these risks were not always shared and therefore the significance of the risks was lost over time.

- **Information sharing and Early Help** – key pieces of information about the risks posed were not always shared and the focus was always on the health needs of the children rather than the risk of sexual abuse. Information about the written agreement was not shared.

- **Hidden adults** – It was evident this was a busy household and adults unknown to practitioners were often present during visits. This was noted by practitioners, but not tenaciously pursued and not through the lens of additional household members posing a risk or indeed understanding how they were involved with the children's daily lives. Practitioners need to be more inquisitive. Agency assessments should be extended to include all adults involved with the children.

- **Children's lived experience/through the eyes of a child** - one of the core principles of effective safeguarding practice is a child centred approach which is focused on understanding the lived experience of children. Research identifies that a child who has developmental and communication needs can be effectively hidden

from view and considerations needs to be given as to how the abuse suffered can compound a child behaviour. There is little evidence of agencies considering speaking to or carrying out a piece of work with the children to consider the wider involvement of family members in a holistic assessment to afford early identification of risk. Assessments did not place the children's lived experiences in the context of their parent's own backgrounds and their immediate and wider family and how this might impact on their ability to protect. Professional need to be attuned to the child's world and pay attention not only to what the child says but also what they are not saying and what their behaviour is communicating.

- **Recognising risk of harm for children with disabilities** – maltreatment of children who are disabled or have chronic illness can be 'hidden in plain sight' with the disability being seen first and the possibility of abuse not considered. Children with learning disabilities are at greater risk of abuse and may only display their distress through behaviour. Practitioners should not assume that challenging behaviour in a child with a learning disability is due to their underlying condition or parenting and should take a holistic approach that considers possible alternative causes.

- **Identification and assessment of the risk of sexual harm** – This review highlights the challenges professionals have, the complexities of working with child sexual abuse, and the importance of clarity regarding risk and need. Identifying sexual abuse is difficult as there is often no physical or medical evidence and children are unlikely to tell someone they are being abused, especially if it is someone they know. Practitioners rely too much on a child making a disclosure, and all front-line practitioners should recognise the signs of sexual abuse and agencies should have strong information sharing protocols, with appropriate training and supervision.

- **The role of the non-abusing parent and extended family** – it has been highlighted in reviews that not enough attention is paid, or assessments completed regarding the needs and circumstances of a non-abusing parent or an evaluation of how to understand their willingness and capacity to keep children safe from sexual abuse and their vulnerability to grooming and exploitation which can undermine that safety. It is critical that there is an assessment of the non-abusing parent's ability to protect and believe children.

- **Recognising the risk of an offender (Police)** - The MASH triages all safeguarding forms which involve children and assures that the risk assessment is correctly graded

and captures the child's lived experience by mandated questions. A child and family scrutiny panel is held monthly and examines three or four randomly selected incidents involving children and may include suspects in custody for sexual offences, the panel ensures the incidents are scrutinised and dealt with in accordance with force policies ensuring the child is safeguarded. Areas of good practice and areas for improvement are identified and fed into training. MAPPA arrangements are in place for offenders managed by the Public Protection Unit (PPU) and all forces apply the Risk Matrix 2000 model for risk assessment and the Active Risk Management (ARMS) for dynamic risk assessment.

- **Understanding familial relationships and access to children (Police)** – Durham Constabulary understands that intra familial child abuse occurs within a family environment, but recent training in sexual abuse recognises that consideration needs to be given in cases where the abuser is family, or the abuser feels like family to the child. Training also summarises a holistic view of issues and the ensuing detrimental effects and the digital forensic unit now looks at intra familial/familial harm when triaging devices.

- **Fast tracking digital devices for forensic examination (Police)** – an experienced sergeant has positioned in the digital forensic lab to review submissions and risk assess and prioritise accordingly. Changes to the submission form have allowed for a greater understanding of risk and there has been an uplift of staff in the in the digital forensic unit.

Conclusion

There are important lessons to learn from this review, these circumstances are a reminder of the need to equip all professionals with the knowledge, skills and frameworks to identify and respond to sexual harm and the need to identify hidden adults within the family home. A number of recommendations were identified to reflect the areas deemed as priority areas for improvement and are outlined below. At the time of publishing the report, the Partnership has yet to determine the specific actions needed to address the recommendations which will lead to the improvement of services.

Recommendations

1a. Darlington Safeguarding Partnership (DSP) to review the effectiveness of weekly review meetings from a multi-agency lens through an audit.

1b. DSP to review the MASH triage processes and membership to ensure all staff who are required to cover are fully trained in the process.

2. DSP to promote reflective discussion standards being implemented by single agencies and work towards multi-agency reflective discussions.
3. DSP to launch a challenge pledge (to be read out at start of multi-agency meetings).
4. DSP to promote the awareness and use of a multi-agency harm matrix tool across all partner agencies.
5. DSP to seek assurance that there is good communication and sharing of information for multi-agency meetings/forums.
6. All agencies to be aware of the need to identify and document additional adults within the home and hidden persons to inform their risk assessments and share within multi-agency forums. Promote the use of genograms. Develop a training tool/video.
7. DSP to undertake a mapping exercise to understand the tools/processes agencies have in place to capture the lived experience of the child which may influence decision making.
8. DSP to provide multi-agency training on identifying sexual harm and including children with disabilities along with the findings and learning from this review.
9. All agencies to implement their own learning as identified in agency reports and the DSP to seek assurance from all agencies that the learning and recommendations from this review is embedded in practice and an ongoing monitoring process is in place to demonstrate impact.