Darlington Safeguarding Partnership

Protecting Children and Adults

A Local Child Safeguarding Practice Review

Family H Overview Report

Report Authors: Rachael Upton and Alison Johnson

Agreed by DSP 3rd November 2023

CONTENTS

1. INTRODUCTION

This review is in respect of 4 children known as Family H[1]. They lived with their parents when the abuse took place.

2. PROCESS

2.1 Following a rapid review process Darlington Safeguarding Partnership (DSP) identified that lessons could be learnt regarding the way that agencies work together to safeguard children and recommended a Local Child Safeguarding Practice Review was undertaken[2].

2.2 It was agreed that the review would be undertaken using a hybrid systems approach and significant incident learning process (SILP) methodology. This process engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time, avoiding hindsight bias or individual blame. Opportunities for improvement within systems for safeguarding children are identified and strengths are promoted[3].

2.3 The review considered agency involvement from January 2012 to January 2023, it was agreed chronologies were not required and that agencies provide a chronological account of their agency involvement in a narrative form.

2.4 To promote family engagement with the review process the Reviewers offered to meet with parents. Parents agreed to this and a date and time convenient to them was arranged by telephone and followed up by letter. Despite this, parents did not attend and engage in the process.

1. [1] It is important to protect the identity of the child and family; the pseudonym Family H has been chosen for this review.
2. [2] A rapid review is undertaken to ascertain whether a Local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made by the National Child Safeguarding Practice Review Panel.
3. [3] As part of the model, agency reports are completed. This gives agencies the opportunity to consider and analyse their practice and any systems issues, identifying learning from the case. Practitioners, front line managers and agency safeguarding leads come together at learning events to consider the case and identify learning. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued.

3. FAMILY STRUCTURE

The relevant family members in this review are:

Family member	To be referred to as:
Eldest child	Sibling 1
Child 2	Sibling 2
Child 3	Sibling 3
Youngest Child	Sibling 4
Mother	M
Father	F
Paternal Aunt	PA
Paternal Aunt's Partner	Adult 1

4. THE BACKGROUND PRIOR TO THE SCOPING PERIOD

Outline of Case

4.1 The H family consists of 4 children under the age of 16. In 2013 the family agreed to abide by a written agreement that stated that the Paternal Aunt (PA) and her partner (Adult 1) should have no unsupervised contact with the H family children as PA previously had both her children removed due to her learning difficulties and her inability to parent safely. Additionally, concerns were raised as she was in a relationship with Adult 1 who had previous sexual offences against children and was felt to remain a risk. He also could not have unsupervised contact. He was classed as a Schedule 1 offender and was not on the Sex Offenders Register.

4.2 Adult 1 and PA were arrested in April 2022 due to suspected sexual offences against children and their devices were seized.

4.3 Adult 1 and PA were released from custody with bail conditions. Adult 1 and PA were not to have any contact with each other, and they were not to have any contact with any child under 18 years by any means. The following month Adult 1 and PA were released without bail conditions and without charge pending investigation.

4.4 On 05/01/2023 The Digital Investigation Unit (DIU) examined the devices that had been seized in April 2022 and found indecent images of children and further enquiries led the police to believe that the H family children were also victims of sexual abuse by PA and Adult 1. It was suspected that their parents were complicit in this, and they were also arrested.

5. FAMILY BACKGROUND.

5.1 The family is white British and Mother originated from outside of local area with minimal support from her own family. Paternal Grandmother provided a high level of support to the family. Religion was not considered to be a feature of the family's lives. Both parents had periods of unemployment and were in receipt of benefits.

5.2 Mother was care experienced and had a history of low mood. During Team Around the Family (TAF) meetings in July 2018, she admitted to struggling with one of the children's behaviours who demanded a lot of her attention and felt this child's behaviours could disrupt other relationships. Parent's relationship was described in agency reports as being under strain, and that lack of sleep was having a negative impact. The mother was also anxious about any social services involvement as she spent time in care as a child and was worried "people will think she is not coping and take her children". She is reported to have worked well with the TAF.

5.3 The agency report from the school indicates that the children presented as happy and content. Siblings 1 and 2 were quiet but participated well in all aspects of school life. Sibling 3 was a more outgoing character and more confident in expressing their wants and needs. The children were always well dressed in the correct uniform and staff did not observe anything warranting any concerns. Homework, including reading at home, was in line with expectations. All three children had wide friendship groups and consistently interacted positively with peers and staff. Education staff who have worked with the children always commented on how respectful, well-behaved, and attentive the children were. All three children's attendance was consistently good, with absences relating to illness only and the children were always prompt and on time.

5.4 The two eldest siblings had some health issues and assessments which identified speech and language and developmental delays. The two younger siblings were generally healthy. All four siblings were up to date with immunisations and there were only minimal occasions of not being brought to health appointments.

5.5 Sibling 4 presented as bright and alert with good eye contact with both parents and was easily soothed and comforted by Mum when upset and handled well by Dad. A warm interaction with both parents was noted by the HV service. When seen at 1-year review responsiveness from Sibling 4 to both parents was noted.

5.6 **Adult 1 and PA**

In 2004 Adult 1 was convicted of 2 sexual assaults on a male child under 13 years and engaging in sexual activity in the presence of a child under 13. At the time of the offence, Adult 1 was 12 years old. He is not a registered sex offender (RSO). The offences occurred when he was under the age of 18 years and in such cases, young people did not get Registered Sex Offender status unless they had committed specific offences such as rape or served a minimum 12-month prison sentence. He was not dealt with as a Potentially Dangerous Person as this did not exist at the time and he did not fit the criteria as he had not been convicted. A multi-agency public protection arrangement (MAPPA) screening meeting was held, and the meeting determined that Adult 1 did not

require MAPPA management. He was classed as a Schedule 1 Offender and had a 12-month referral order.

5.7 PA had 2 children removed from her care in 2012 and 2015. There is minimal information relating to this in agency reports other than the children were removed due to PA's inability to provide safe care and the risks posed by Adult 1 whom she was in a relationship with.

6. GOOD PRACTICE

6.1 The authors would like to highlight the amount of work undertaken to produce the agency reports, together with valuable contributions to the practitioner events. The purpose of this review is to learn and influence practice on the ground and to improve service provision to families. It is not to allay blame and therefore essential to identify good practices and ensure this is reflected in reports and shared with agencies. The examples of good practice identified are as follows:

1. There was a Team Around the Family (TAF) in place for Sibling 2 due to their Special Educational Needs and these meetings were held regularly as per guidance at the nursery. Parents attended the meetings and appeared to be open and honest with professionals about their concerns and the support they required around Sibling 2's additional needs.
2. Nursery staff contacted police and Children's Front Door when they were alerted to PA and Adult 1 speaking to the family when on a school trip.
3. In 2018 the Health Visitor (HV) advised the Nursery to make a social care referral when she was informed by the nursery staff that Siblings 1 and 2 were upset around males. She also documented concerns in the Significant Events section of the records and ensured the new HV was aware of historical concerns.
4. The HV informed Children's Social Care when parents shared they were living opposite to and working with Adult 1.
5. The referral to Children's Social Care on 05/01/2023 progressed from CIAT (Children's Initial Advice Team) to Children's Social Care within 90 minutes with the children being protected under Police Powers of Protection and placed in foster care that day, Interim Care Orders secured the placement with foster carers the following day.
6. The Police informed Children's Social Care when PA told them she was pregnant and trying to conceal this from agencies.
7. The Locum GP of Adult 1 identified that there were no safeguarding concerns documented within the computerised records despite knowledge of the risks and escalated this. This resulted in a liaison with the couple's social worker.

8. The Nursery Nurse and Physiotherapist were tenacious in recording the details of unknown adults within the home.
9. There was good communication between Safe Families and the family, and the volunteers provided consistent flexible support. They shared information with the Local Authority in a timely manner.

7. ANALYSIS BY KEY EPISODE

7.1 Key episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Family H. The episodes do not form a complete history but are key from a practice perspective to consider when there was professional involvement that informed the review. From the information gained within the agency reports together with the discussion at the learning events, the following key episodes provide the analysis and enable the review to identify learning for Darlington Safeguarding Partnership (DSP).

HV AND MIDWIFERY REFERRAL 2016

7.2 In March 2016 the Health Visitor (HV) made contact with Social Care raising concerns in relation to Adult 1 living opposite parents and that parents were working with Adult 1 in a mobile phone shop. The HV was aware that there was a written agreement that Adult 1 and PA should not have unsupervised contact with children. In the same month, 2 referrals were sent by the Community Paediatrician (County Durham and Darlington NHS Foundation Trust (CDDFT)) requesting support for sibling 2 due to developmental delay. The midwife also made a referral to Children's Social Care as the mother was 28 weeks pregnant and there had been previous involvement from social care.

7.3 This was an opportunity to review the written agreement alongside the consideration of the developing vulnerabilities within the family and how this might impact on parent's ability to protect. Consideration could also have been given to the power dynamics within the family and the potential for the possible grooming of adults.

7.4 Within the Social Care Agency Report it was discussed that there has been a change to practice. If there is any information to suggest children might have contact with a person who poses a sexual risk, previously the business support team assisted in the preparation of case history, now a social worker undertakes this as this information informs the contact enquiry and any subsequent action, including referrals to social care. This ensures that current practice considers the history of the child when any concern is raised and therefore the response to any concern is strengthened with social work oversight of the history from the outset. CIAT's current practice ensures the history of the child is always considered when any concern is raised.

7.5 There was no outcome documented in the HV records following the referral, however during the practitioner event the HV confirmed that the current practice would be that all referrals are now followed up with an email,

reiterating the referrer's concerns and what actions will be taken. There is no evidence that the HV concerns were shared with the GP. Some HV information may have been visible to the children's GP practice but only if the GP was alerted to its existence. There is no record of any GP Practice meetings taking place where the HV could have shared her concerns. The Named GP described that currently the GP practice meetings are well embedded into GP practices in Darlington, and they are valued by the GP Leads. The Named Nurse for the 0-19 service also explained that The Safeguarding 0-19 Link Meeting Standard has been in place for approximately 3 years and has a criterion for selecting which and how many cases to discuss. A review on August 23 between the Named GP and the 0-19 Service manager highlighted some communication issues. These are being addressed by the quarterly GP Leads meeting, which the Named Nurse Child Protection and 0-19 Service Manager attend and are chaired by the Named GP.

Information sharing issues in general, with Safeguarding Liaison Meetings in particular, are a standing item at the Quarterly meetings of GP Child Safeguarding Leads. The aim is to achieve best practice in effective information sharing.

7.6 There are no details of the referrals from CDDFT in the agency reports however the Named Midwife confirmed during the practitioner event that current practice includes the requirement for the Midwife to raise with their safeguarding team if a referral they submitted does not receive the response they expected. There is also now a quarterly audit between the front door and CDDFT Named Nurse that reviews the quality of the referrals and the responses.

8. REFERRAL TO EARLY HELP FROM CDDFT 2017

8.1 In September 2017 the Community Paediatrician (CDDFT) contacted Children's Social Care to request support in relation to Sibling 3 being developmentally delayed. The outcome was to transfer to Early Help Support to consolidate with work ongoing with Sibling 1 and Sibling 2.

8.2 The agency report from Children's Social Care identified that the risk of sexual abuse from Adult 1 was not considered within the Early Help Assessment and the plans and review of this did not have any focus on the potential for the children to be sexually abused, nor did the assessments place the children's lived experiences in the context of the parent's own backgrounds and their immediate and wider family and how this might impact on their ability to protect.

8.3 Children's Social Care also identified within their agency report that the plans and the Early Help Assessment were dominated by multi-disciplinary involvement around the children's physical needs. It is not clear which health agencies were invited to the TAF meetings. The information regarding the risk posed by Adult 1 and PA was not considered by agencies involved with the family at this time. It is also known that M had previously been willing to discuss

the written agreement with professionals so the TAF meetings could have been an opportunity to review and update this with her. The Physiotherapy single agency report indicates that their practitioners were not aware of or invited to the TAF meetings and there is no record of TAF meetings within the Speech and Language Therapy (SALT) agency report.

9. NURSERY REFERRAL 2017

9.1 During a school visit to the seaside in July 2017 a parent of another child questioned staff as to why a known paedophile was talking to Family H on the beach. Up to this point nursery staff were not aware of the risk posed by PA and Adult 1.

9.2 Staff recall different versions of how this was followed up and there is no documented information held in the school of this incident. One staff member recalled the previous Deputy Head contacted Children's Front Door and was told to contact the police, which she did and was told that the claims were unsubstantiated and there was no further action. Another member of staff recalled that the Deputy Head Teacher rang the police and was told it would be investigated. From the police recording it appears it was investigated as police went out and visited the family, however, there was no crime confirmed and therefore no further action was taken. So, the information recalled by staff at the school are not different versions, both pieces of information are correct. Both staff said that as far as they were aware, there was no further contact from the police with the school following the conversation the Deputy Head Teacher had with the police. The recording of possible safeguarding incidents would now be documented on the Child Protection Online Management System (CPOMS) to assist accurate recording of historical information.

9.3 The police spoke to M and F when they returned home, and both stated they did not know that PA and Adult 1 were going to be at the seaside. They stated they knew he was a 'sex offender' and had done so since 2013 when they were made aware of this by Children's Social Care. M and F stated they have some type of written contract with social services that allows them to associate with Adult 1 if he is not left alone with the children.

9.4 The police shared this information with Children Social Care via email on 14/07/2017 to ensure Adult 1's contact with the children had been assessed. There was limited information recorded for the family on the police system. When the police spoke to the parents the police view was there was no indication parents were unable to protect their children at this point. Both parents were aware of the risk posed by Adult 1 and explained they understood the terms of the written agreement. The police did not have knowledge that PA was included in the written agreement at this stage.

9.5 Children's Social Care contacted M who clarified she had a written agreement at home and stated Adult 1 was never left alone with the children. The social worker spoke to nursery staff who confirmed to their knowledge the children

were not left alone in the care of Adult 1 during the nursery trip, however, there was one point where parents were with their children alone without nursery oversight.

9.6 There was an additional concern raised by Nursery staff who reported Sibling 1 could get quite upset when unknown males attend the nursery. Children's Social Care advised nursery staff to keep an eye on the situation and if Sibling 1 was to make any disclosure to contact the Police and Children's Access Point (Children's Social Care).

9.7 There was no evidence of professionals attempting to view the written agreement or ask M or F to provide this document. Furthermore, this would have been an opportunity to ascertain parent's understanding of the risk posed by Adult 1 and PA. Professionals appeared to readily accept the parental account of the written agreement and did not show sufficient curiosity about the reality of the children's lives.

9.8 There was no evidence of agencies considering speaking to or carrying out a piece of work with the children when there was clear evidence of impact from the information nursery staff had shared. This was an opportunity to consider the children's lived experience and to consider the wider involvement of family members in a holistic assessment to afford early identification of risk. In this episode historical information was not fully considered which is likely to have impacted the ability of professionals to complete an accurate assessment to support effective multi-agency working. Key information about Adult 1's previous history and risk should have informed risk assessment and planning from an early stage. Risks need to be seen as dynamic factors that can change as circumstances alter, therefore they need to be continually reviewed and assessed.

9.9 There needs to be clear documentation of what information was shared, and action taken. Working Together to Safeguard Children 2018 emphasises the importance of effective communication to coordinate a full picture of the child's needs and circumstances and notes that everyone has a role to play in identifying concerns, sharing information, and taking appropriate and timely action.

9.10 In analysing this key practice episode, the discussion generated at the learning event, and the information provided in the agency report highlighted that this episode would now be looked at very differently by Children's Social Care. There is clear evidence of child impact and with a parent stating there is a written agreement in place with sufficient risk known to them about a family member to their children. In this instance, there was the opportunity for multi-agency working with the nursery, health visitors, police, and children's social care. At this stage, a step up to social care could have been considered, following discussion with the social care management team in CIAT this episode would now be recorded in a contact enquiry and the history entered for the children. A clear decision supported by rationale by the social care

management team would have supported any step up to social care or decision for the family to remain open to Building Stronger Families (BSF).

9.11 This would have been an ideal opportunity to progress a referral as there were several agencies already involved and parents were willing to engage. There have been changes in practice since whereby any referral to children's social care is reviewed weekly, additionally, Police and CIAT work together to identify any children that might be at risk of being sexually abused. Regarding the use of written agreements, the current practice is to ensure that if a written agreement or contract of expectation is in place this is for a short period of time and should not be a tool used in isolation to form assessments or plans.

10.0 NURSERY ADVISED BY HV TO MAKE REFERRAL DUE TO CHILDREN'S BEHAVIOUR 2018

10.1 In September 2018 the Nursery rang the Health Visitor expressing concerns that Sibling 1 and Sibling 2 became very agitated and upset in the presence of men. This is the second time the Nursery raised concerns regarding the children's behaviours. It was documented by the HV "in view of the previous social care involvement and written agreement regarding extended family members I advised the nursery to refer to social services". This was not followed up by the HV and there is no record of this professional discussion within the nursery agency report. There is also no record of a referral being made within Social Care records.

10.2 During the Practitioner event, the HV confirmed that current practice now includes a cumulative risk assessment at every contact. If this indicates that a risk has increased, then the HV would discuss the family in Safeguarding Supervision or ring the SPOC (Single Point of Contact) for advice and there would have been the opportunity to reflect and follow up on the advice given to the Nursery Staff.

10.3 There have also been changes to how nursery staff record concerns since 2018 as identified in their agency report. Previously records were paper-based and were not always accessible and could be lost however the introduction of CPOMS, an electronic record-keeping system, has meant that no paper-based documentation now needs to be transferred between settings.

10.4 The Nursery staff are also now less reliant on parental reporting of any safeguarding concerns when a child first starts nursery as information is now also shared verbally during Local Authority Early Years transition meetings and SEND transition meetings, and the implementation of CPOMS means that all safeguarding information is shared electronically upon registration at a new setting.

10.5 In July 2018 the Low Incidence Needs Service (LINS) which supports children with visual or hearing impairment, had documented that during a nursery visit: Sibling 1, sibling 2 and another child were doing activities in the community

room. A boy walked past to go to the toilet and came out naked (bottom half). On seeing the boy, Sibling 2 became upset and required comforting. Nursery staff were informed, and the incident was written in the Nursery's Concern Book. There is no record of this within the nursery agency report.

10.6 The LINS worker emailed the Early Help Team for advice. The case had been closed to Early Help several weeks before. Early Help advised continued monitoring and to make notes of any further incidents. It is not clear if the LINS worker outlined the risks posed by Adult 1, as they had been made aware of the incident during the nursery trip also that parents were associating with an adult who was a known risk to children and the risks were also outlined in the original referral to their service. The exchange is only recorded as a contact in Social Care records rather than a referral as the LINS worker emailed her concerns rather than making a referral to the front door.

10.7 Changes at the Front Door now mean that practitioners can phone for advice and guidance, and this will then result in a referral to Children's Social Care if required. This could have been another opportunity for historical information to be reviewed and ensure the children were spoken to.

10.8 Children's Social Care discussed at the practitioner event that there had been changes to how referrals were processed since 2018. If somebody were to make a referral with a concern now, it would go through the children's Front Door, then to a team manager, so there would be oversight and clear direction.

10.9 It is evident that some agencies were considering the link between the children's behaviour and the possibility of sexual harm at this point, however there was a lack of professional curiosity and challenge leading to missed opportunities to identify this risk.

11.0 REFERRAL FROM PRIMARY SCHOOL LOW INCIDENCE NEEDS SERVICE (LINS) TO EARLY HELP 2018

11.1 There was ongoing input from early help for Siblings 1 and 2, then following a request from the acute hospital Trust (CDDFT) for support in relation to sibling 3's developmental delay, this was transferred to Early Help to consolidate this support in 2017.

11.2 Therefore, when the LINS teacher (qualified teacher for the visually impaired) completed a multi-agency referral form (MARF) in February 2018 for early help because M and F reported they were struggling with Sibling 2's behaviour, this was referred to Safe Families (a voluntary sector organisation offering support to children and families) by the Early Help team.

11.3 The initial referral request included for Safe Families to provide overnight care of Sibling 2. The referral also noted that a written agreement was in place from 2013 stating PA's partner Adult 1 could only have supervised contact and he

was 'on the sex offenders list'. Safe Families did not request further clarity on who Adult 1 was or what the specific risks were.

11.4 An initial assessment and planning visit was undertaken at the family home on 29/05/2018 by the Family Support Manager. The paternal Grandmother (PGM) had care of Sibling 1 and Sibling 3, the Family Support Manager was informed by M that the Paternal Grandmother provides regular care for the 3 children and sometimes has care of them overnight. This information had not been noted on the referral form, Safe Families informed the Local Authority of this to further understand the level of support required from Safe Families. The Local Authority practitioner reported she was not aware at the time of the level of support provided by paternal grandmother. This was identified as good practice by Safe Families for sharing this information with the Local Authority Practitioner.

11.5 It was agreed support would take place every 2 weeks with volunteers taking Sibling 2 out. The volunteers were introduced to the family at the family home when M, F, all 3 children, PGM, and F's brother were present. Sibling 1 informed the Family Support Manager that PGM and F's brother would be looking after them as M and F were going to work.

11.6 There were 10 episodes of support provided by the volunteers over a period of 5 months from 30/06/2018 – 10/11/2018. The first 3 episodes took place in the family home and at the request of Sibling 2 the volunteers took Sibling 1 and 2 together.

11.7 During this period of support there were no additional concerns noted, however external family members were present on a regular basis, with volunteers noting that 'there are always a lot of people in the house and that F's brother appears to be living there'.

11.8 It was also noted that Sibling 1 and Sibling 2 were fearful of loud noise specifically a drill they had heard while outside and the kitchen mixer when making cakes.

11.9 The Family Support Manager attempted to contact the referrer to share the above information and discuss the next steps for support, this again was identified as good practice. On 17/10/2018 Safe Families were advised by the nursery that the Local Authority practitioner had closed the case in July. They were also informed the family had been provided with additional funds for days out and it was agreed that there was no reason why the parents would not be able to take the children out themselves. Safe Families decided to close the support.

11.10 The Family Support Manager visited the family on 31/10/2018 to undertake a completion review with the family. Both parents were out, and F's brother had care of Sibling 2 and Sibling 3. This was followed up with a telephone call with M later that day who stated the situation was much better and they continued

to have support from extended family, specifically F's brother, and mother. A final visit was arranged for the volunteers and the children to say goodbye.

11.11 It was noted in the agency report that family members were present on a regular basis and only two dates where it was recorded; on 14/07/2018 F's brother was present and on 13/10/2018 there was another uncle with a dog and friend present. A final completion review noted that M and F were out, and F's brother had the care of Sibling 2 and 3. Volunteers also noted 'there are always lots of people in the house and that F's brother appears to be living there.

11.12 When there is an additional request for support for a family that is open to agencies, consideration should be given to carry out an assessment of what the current family needs are, what support the family is receiving, and who the key family members are who are actively involved with the children's lives. Any new significant adults should be assessed as part of ongoing support plans regarding risks and supportive factors and recognise the significance of this in the child's daily life.

11.13 Professionals should review and update assessments when there is new information or new requests for support, to gain a holistic perspective and not be viewed through a single lens such as behaviour or disability. Additionally, practitioners need to consider the significance or underlying meaning of a child's behaviour.

11.14 It has been recognised that a high proportion of Local Child Safeguarding Practice Reviews/Serious Case Reviews (LCSPRs/SCRs) have been for children not receiving statutory Social Care support. This underlines the importance of high-quality 'front door' assessment, signposting, and the critical roles of universal services, early help, education, health, and police in safeguarding children.

11.15 When families are referred to any support service there should be regular updates of plans, what has been implemented, and any new issues that may need to be considered that are impacting on the children's lives. There is evidence in this case of parents struggling to meet the needs of the children throughout their lives and the focus was on this and no consideration of the risk from Adult 1 and the potential for children being exposed to sexual harm.

11.16 The discussion generated at the learning event and from agency reports established that since the re-modelling of the 'Front Door' which occurred in March 2020, early intervention work has been known as 'Building Stronger Families' (BSF) and BSF work alongside the CIAT. This provides a holistic approach and is not just about early help. The service now has a skilled and varied workforce with increased management oversight. Any referral to the Children with Disabilities Team would go through the front door to enable information sharing and discussions between BSF and the front door. There would be a liaison with the children with disabilities team, therefore providing

a triangulation of the request and looking at what could be achieved within the children with disabilities team as opposed to early help. In this episode, there had been a conversation with the school and early help as to whether the Children's Disabilities Team was appropriate, and the outcome was it would remain open to early help.

11.17 Current practice is that no family open to BSF should have a written agreement in place and if this was the case a discussion with BSF and CIAT would take place and a step-up progressed which social care would lead. Safe families have strengthened their approach in relation to assessment including risk assessment and risk planning, this includes further exploration of potential risks posed by individuals in contact with the family, ensuring volunteers fully understand the risk plan. Communication with the Local Authority has been strengthened with clear guidance for the Local Authority to inform Safe Families of any changes in case holding or case closure, and the family must remain open to the Local Authority whilst Safe Families support is provided. Written updates from local authority practitioners are requested at a minimum of every 12 weeks and Family Support Managers are required to keep local authority practitioners informed of how support is progressing every 4 weeks.

12.0 MIDWIFERY REFERRAL 2020

12.1 In March 2020 M booked in with maternity services. This pregnancy was during the COVID-19 pandemic, and all appointments were unaccompanied. Routine enquiry was completed with this pregnancy and enquiries were made regarding how M was feeling about the pregnancy as it was reported this had been unplanned.

12.2 The midwife had explored what family support was available for M, who disclosed she had suffered from postnatal depression and was taking anti-depressants until 2019.

12.3 The midwife contacted Children's Social Care to clarify any previous involvement and was advised there was no current involvement and no outstanding needs. There is limited evidence in the documentation which would indicate early help was considered or offered to M especially as this was her fourth child in addition to Sibling 2 having significant difficulties.

12.4 There were no safeguarding concerns raised by the community midwife or within the contact enquiry. The community midwife was advised by Children's Social Care to go back and speak with parents and ask what help the family would like. There is no documented evidence this was explored with the family and if further action was taken.

12.5 Professionals need to make clear what support is required by the family and to have documentation of the outcome. This may warrant further discussion with the family and other agencies to establish what effective support is required.

12.6 The discussion generated at the learning event established that this contact was in March 2020 when the service was first remodelled and BSF would usually have been offered but was not in this instance. The pregnancy was in the early stages the parents were asking for support with their current family composition.

12.7 It was acknowledged by the Named Midwife that this is an area of learning for midwifery to explore further. Midwifery services have redeveloped the antenatal risk assessment which includes asking about family members, and any history of social care involvement to consider current and historical vulnerabilities to facilitate analysis of risk, this is revisited during pregnancy. There is now a Named Midwife and maternity safeguarding team in place since 2021 that provides training and supervision for maternity staff.

13.0 PRIMARY SCHOOL REFERRAL 2021

13.1 In April 2021 the Primary School made a referral to Children's Social Care as " Sibling 1 had a plaster on their arm and disclosed to a Teaching Assistant that Nana had dragged sibling 1 down the stairs and dug her nails in, and that father had told sibling 1 to hide the scratch behind a plaster and not tell anyone". The school's Designated Safeguarding Lead (DSL) spoke to Sibling 1 who confirmed the events and stated that they stay with Nana every Thursday-Sunday. CIAT advised Teaching Assistant to speak to M and offer support around parenting/appropriate care for Nana when looking after the children. M confirmed Sibling 1's account and said that Sibling 1 had been playing up, so Nana grabbed sibling 1's arm to take them downstairs. M said Nana apologised when she saw she had marked Sibling 1's arm.

13.2 M asked for support with Sibling 1's behaviour at home. The DSL then discussed with the Parent Support Advisor how to support the family moving forward. The Primary School was not aware of the risks posed by Adult 1 or PA. Their agency report identified improvements in information sharing since this episode. Nursery to Reception transition processes now involve asking a named member of the Nursery staff specific questions relating to safeguarding concerns and external agency involvement rather than relying solely on parental reporting.

13.3 The advice from CIAT to gather more information does not seem appropriate as there was already sufficient evidence that Nana was not coping with the children's behaviours resulting in Sibling 1 receiving an injury, and the child being asked to cover up the injury. M was also clearly asking for support, and it would have been an ideal opportunity to engage the family. As the threshold for initiating further assessments had been met, and the mother was requesting support it would have been appropriate for Social Care to speak to all the children in the family. Again, if historical information had been determined or there had been liaison with the HV the increasing risks to the children may have been identified. Although other agencies held information regarding the risks the health representation in the Multi Agency Safeguarding Hub (MASH) may have been a further opportunity to identify the existence of the written agreement and consideration could have been given to whether

Grandmother was aware of the risks posed by Adult 1 and also whether the escalating behaviours of Sibling 1 could be as a result of experiencing abuse.

13.4 Although the school was advised by social care to gather more information, the outcome of this was not followed up by Children's Social Care and the case was closed with no further assessments. There are now weekly review meetings that review decision-making in relation to contacts received into the Children's Initial Advice Team, in particular all referrals to Childrens' Social Care, as well as contacts where the primary factor of abuse is identified as the concern and the outcome is one of information/advice/signposting. This review meeting would now identify that the referral had not been followed up. Although this is a positive improvement to the Front Door, there is no health input in these weekly reviews. An audit that includes Health could provide assurances that the decision for no further action or advice only was an appropriate one from a multi-agency lens.

Recommendation 1a: DSP to review the effectiveness of weekly review meetings from a multi-agency lens through an audit.

14.0 DAILY TRIAGE MEETING WITH POLICE AND SOCIAL CARE APRIL 2022

14.1 The Police agency report details that on 19/04/2022 the safeguarding report was reviewed in the daily triage meeting. The report rationale stated that due to Adult 1 and PA's child being adopted, and no other children being linked to the report, it was agreed that there was no requirement for the report to be shared with Children's Services because the children checked in this meeting were adopted. However, Sibling 2 was mentioned in the written report as being previously linked to PA, but the link to Sibling 2 was not evident at the beginning of the report where persons involved are populated, it was referenced further in the text of the report. It is not clear whether Police shared the information in that triage meeting and social care never received a written copy. On that day there was a change in the usual police personnel at the triage meeting which resulted in a change in the normal procedure. The report was also shared with Harrogate and District NHS Foundation Trust (HDFT) (0-19 Service), usual practice is for forms to be automatically sent if a child is identified in the report. The information sent to HDFT was in relation to the two children previously removed from the care of PA and Adult 1 and sibling 2. Again the link to Sibling 2 was not evident at the beginning of the report where persons involved are populated, it was referenced further in the text of the report, meaning when the report was received by HDFT it would have only been shared to practitioners linked to PA and Adult 1's children who were at this point deducted from HDFT system due to their adoption and no Sibling 2. Current police practice which would have linked Sibling 2 on Polmap would have led to Sibling 2 to be populated into the persons involved section of the report, making this visible to agencies viewing the report.

14.2 The daily triage meeting is attended by a police detective, the team manager and or deputy manager from Children's Services front door, an early help

manager and or worker, 4Kids representative (a bespoke Darlington initiative between Police and Children's Social Care that focuses on preventative work with families where there is evidence of domestic abuse in the household), CIAT IDVA Harbour worker, and a housing representative, who all meet via teams. A representative from Health does not attend regularly. The information regarding the links to the Family H children was available to police, but these historical links had not been identified previously within Children's Social Care and so were overlooked. Health was not present they were unable to share any known risks or linked relationships.

14.3 Safeguarding reports that are not felt relevant to be shared are documented on police records with a rationale for why. Children's Social Care does not retain information that is deemed unnecessary to share, for instance, if the adults have no children or no children linked to them, however, if the information shared is deemed relevant (i.e. re: domestic abuse or sexual abuse) then a record will be made on the child's file for information purposes only.

The link to sibling 2 was overlooked and it was known at this time the other children were linked to Adult 1 and PA. Therefore, the risks to family H children went unnoticed at this point.

Recommendation 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.

15.0 REFERRAL TO EMERGENCY DUTY TEAM (EDT) BY POLICE APRIL 2022

15.1 Following the arrest of PA and Adult 1 at the railway station in April 2022 the Emergency Duty Team (EDT) was contacted and confirmed that PA and Adult 1's first child was subject to an adoption order but could not confirm the status of the second child as their records were restricted. When PA and Adult 1 were bailed to family addresses the EDT was consulted and confirmed there was nothing in their records since 2018 that related to PA's father and there were no children listed at the address.

15.2 The EDT needs to have access to closed cases and for links to wider family members to be available. When children are adopted the case files of the children are closed, this is an issue that is being looked into currently as at present no professional is able to access these, and links to the children are not visible.

15.3 The EDT was only able to share information regarding Adult 1 and PA's first child as the records were restricted due to the children being adopted. It was felt to be fortuitous that the EDT was able to establish at least one of their children's information as usually this would not be available either. There would be a benefit in the EDT having access to closed cases due to adoption and having clear links with the wider family and their children.

16.0 IDENTIFIED LEARNING THEMES.

16.1 From the information extrapolated from the agency reports and the discussion at the practitioner event several key themes have emerged.

17.0 PROFESSIONAL CURIOSITY AND CHALLENGE

17.1 On reviewing the key episodes highlighted in this case there were some good examples of professional curiosity, for example when the Nursery Nurse requested details of the male present during her visit however there are also several examples from agencies where this could have been improved. A report by the Care Quality Commission notes that "The risks to many children are not always obvious and require a continuous professional curiosity about the child and their circumstances. The emphasis must be on both identifying and supporting those in need of early help, as well as those at risk of 'hidden' harms." (CQC 2016)[4]

17.2 Agency reports also identified that there was a lack of challenge from agencies as detailed in the key episodes.

17.3 The Darlington Safeguarding Partnership Multi-Agency Practice Guidance and Resources for Practice identifies professional challenge as a positive activity and a sign of good practice and effective multi-agency working. Being professionally challenged should not be seen as a criticism of the person's professional capabilities.

17.4 Both national and Local Child Safeguarding Practice Reviews (LCSPRs) continue to draw attention to the importance of interagency communication and have identified an apparent reluctance to challenge interagency decision-making. When there is a lack of challenge from practitioners, this may not be because they do not feel able to or know how to challenge, it may be that they did not recognise the need for challenge at that time.

17.5 Practitioners need to be able to make consistent protective child-centered decisions, made from an evaluation of historical factors as well as current and dynamic risk factors. The NSPCC (2020)[5] states that professionals need to remain curious about the source of children's distress, behaviour, or physical indicators of abuse, even if other agencies' assessments are inconclusive.

17.6 Serious Case Reviews and LCSPRs often identify the same learning such as lack of professional challenge, decision-making, professional curiosity, assessment of risks, and over-optimism. We expect a lot from our practitioners. We know that work to ensure children and adults at risk are protected from harm requires

[4] CQC Report (2016) Not Seen, Not Heard: At review of the arrangements for child safeguarding and health care for looked after children in England, p. 5

[5] NSPCC Child sexual abuse: learning from case reviews. Summary of risk factors and learning for improved practice around child sexual abuse. January 2020

sound professional judgements to be made. It is demanding work that can be both distressing and stressful.

17.7 Eileen Munro's review of child protection championed the use of effective supervision as a means of improving decision-making, accountability, and supporting professional development among social workers. She also identified it as an opportunity to question and explore an understanding of a case. (Munro 2011)[6]

17.8 Supervision and Reflective Practice can be effective in promoting curiosity and safe uncertainty, practitioners require space to think about their own judgements and observations.

17.9 Ferguson (2018) [7]highlights the unconscious emotional forces that can distort professional practice and stresses the importance of regular reflection with others.

17.10 Staff involved in safeguarding must have access to advice and support from professionals experienced in the field of safeguarding children. Reflective practice allows recognition and reflection on experiences to learn from them and improve ways of working.

17.11 It is important to acknowledge that each partner agency will have its own governance arrangements, supervision culture, and organisational structure that will affect the way in which safeguarding supervision is delivered. Reflective discussions should not replace organisational policies that set out the specific supervision processes within agencies.

17.12 Standards for reflective discussions could include a discussion of the risks to the child/young person and the opportunity for the practitioner to be professionally curious. For example, has the practitioner followed up on appointments parents have said they had? Have they confirmed histories given by parents with other agencies, and have they reviewed historical records?

17.13 Reflective discussions also need to maintain focus on the lived experience and the impact on the child and identify appropriate decision-making.

17.14 These discussions can also create the opportunity to explore the potential for personal bias or erroneous beliefs and consider the well-being and support of practitioners.

Recommendation 2- DSP to promote reflective discussion standards being implemented by single agencies and work towards multi-agency reflective discussions.

[6] The Munro Review of Child Protection: Final Report A child-centred system. May 2011

[7] Ferguson, H. (2018). How social workers reflect in action and when and why they don't: the possibilities and limits to reflective practice in social work, Social Work Education, 37:4, 415-427

Recommendation 3 - DSP to launch a challenge pledge (to be read out at the start of multi-agency meetings.

18.0 ASSESSMENT OF RISK

18.1 The risks posed by Adult 1 and PA were never fully explored or understood by agencies involved with the family. The Children's Social Care Agency Report identified that any risk assessment that would have explored and analysed the risk posed by Adult 1 and PA was not applied to the work undertaken in the early intervention framework.

18.2 Although some agencies held information regarding the risks, these risks were not always shared.

18.3 There was evidence that practitioners were raising concerns regarding the link between the risks posed by Adult 1 and PA and the children's behaviours but there was no robust risk assessment completed that may have helped to inform a referral to Social Care.

18.4 The HDFT report highlights that a cumulative risk assessment now takes place after every contact so practitioners are continually reviewing risks to families however there is no consistent multi-agency risk assessment tool available that can be used for all agencies that would assist practitioners in understanding previous as well as existing risks.

18.5 There have been broad changes to the Front Door which took place in March 2020, particularly in relation to the improvement in partnership working and the discussions and decision-making between BSF and the social care management team in CIAT. When a contact enquiry is made with the Front Door, basic contact information is gathered which includes: Risk/RAG rating, consent, disclosure, a brief history of information held on the system, family household details plus significant others, ethnicity, key agencies involvement, the person making contact, details of the contact and any other additional information from other contacts that have been received alongside.

18.6 Relational telephone discussions rather than e-mail referrals allow for more case discussions of worries and more questioning/curiosity. This could be strengthened further by the use of the Harm Matrix. Its use could also be extended to multi-agency use within early help and Child in Need (CIN).

18.7 When assessing child abuse and neglect it is crucial to gather specific, detailed information about the harm. This involves clearly identifying the harmful behaviour, its severity and frequency, and its impact on the child. The harm matrix could help practitioners to explain worries in a clear and structured way, leading to a good understanding of the previous and existing harm that children may have been exposed to.

Recommendation 4: DSP to promote the awareness and use of a multi-agency harm matrix tool across all partner agencies.

19.0 EARLY HELP AND INFORMATION SHARING

19.1 In many serious case reviews, there is an element of poor information sharing and communication (HM Gov 2016)[8].

19.2 Despite regular TAF meetings taking place, key pieces of information regarding the risks posed by Adult 1 and PA were not always shared and the focus was on the health needs of the children rather than the risks of sexual abuse. Reports from SALT and Physiotherapy highlighted that they were not aware of or invited to TAF meetings and Safe Families were unaware that the case was to be closed by the Early Help Team.

19.3 Working Together (2018)[9] states that "Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe".

19.4 Darlington Children's Social Care is currently in the process of setting up Darlington's Early Help and Prevention Strategic Board. It's aim is to ensure the right people are 'around the table'. The Board will bring together partners who can help transform the Early Help agenda with an agreed shared vision for children and families in Darlington. The Board will be responsible for the strategic and operational delivery of effective, targeted, and coordinated preventative and early help support to children, young people, and families.

19.5 The HV and Nursery staff attended the TAF meetings, however information regarding the written agreement was not shared. It may be that the significance of the risks was lost over time in the absence of any copy of the written agreement in the HV records and the lack of curiosity and challenge regarding the content of the agreement. There is also no record of the Nursery or the Health Visitor sharing information regarding concerns previously raised by Nursery staff. The Safe Families practitioners were unable to share their assessments as the case was closed to Early Help without liaison.

Although the Early Help Plans were shared with the GP there would have been added benefit in the children being discussed at the GP Practice meetings. Information regarding the risks posed by Adult 1 was within his GP record but was not easily accessible and there was no alert on his records therefore had Adult 1 presented at the surgery staff would not have been alerted to any risks. The GP practice in question has identified this within their single agency learning.

Recommendation 5 – DSP to seek assurance that there is good communication and sharing of information for multi-agency meetings/forums.

[8] HM Government (2016) "Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014" London Department for Education

[9] Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children July 2018

20.0 HIDDEN ADULTS

20.1 It is evident in the agency reports this was a busy household with unknown adults often present during visits by professionals. This had been noted by some agencies and to a degree pursued, but not tenaciously and not through the lens of additional members in the household posing a risk.

20.2 There has been a great deal of focus on hidden fathers 'Myth of Invisible Men' (2021)[10], and how to involve men in child protection work, this is predominantly related to male partners. However, in this case, there were unknown adults who were visible in the home but 'hidden' in professional risk assessments and understanding of how they were involved with the children's daily lives. Agency assessments should be extended to include all adults involved with the children, whether male or female to identify any risk or support and caring capacity they may provide. Practitioners need to be inquisitive and ask questions about all adults, not just father figures, and not wait to be informed by other professionals (NSPCC 2015)[11]

20.3 Consideration of how this can be achieved would be supported by applying curiosity of who is present at the home, to have this documented and an assessment of cumulative risk at each contact. This can be further supported by supervision, training, and inter-agency communication, with clear action plan documentation to support this.

Recommendation 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.

21.0 CHILDREN'S LIVED EXPERIENCE

21.1 Working Together 2018 clearly states that one of the core principles of effective safeguarding practice is a child-centred approach which is focused on understanding the lived experience of children and seeking their own views about their lives and circumstances. This is reinforced by the United Nations Convention on the Rights of the Child[12], which recognises a child's right to expression and to receive information.

21.2 Several reviews have found that professionals had paid insufficient attention to the lived experience of the child's daily life with children often viewed through a single lens for example, practitioners focused on a child's disability or health condition, or there was insufficient focus on the lived reality of the child's life even though the family was known to services and seen regularly. Throughout

[10] The myth of invisible men: safeguarding children under 1 form non-accidental injury caused by male carers. (2021) The Child Safeguarding Practice Review Panel. Gov.uk

[11] Hidden men: learning from case reviews (2015) NSPCC production https://learning.nspcc.org.uk/media/1341/learning-from-case-reviews hidden-men.pdf

[12] https://www.unicef.org/child-rights-convention

this review, there is a lack of evidence of the voice of the child and little understanding of the children's lived experience.

21.3 Lived experience can be understood in several ways including considering the child's life in different contexts such as community or school as well as home. Thinking about all aspects of the child's health and wellbeing not just in isolation. Reflection on the impact of experience and their cumulative impact, exploring and reflecting on how the child may be experiencing decision-making, planning, and professional intervention. A review of SCRs [13]suggested that insight was especially likely to be compromised when children were not being seen independently, taken to health appointments, or not attending school.

22.4 With Family H there was agency involvement specifically with sibling 2's disability and parental challenges coping with what was deemed 'difficult behaviour', without wider consideration given to the cause outside of the child's disability. Research identifies a child who has developmental and communication needs can be effectively hidden from view; consideration needs to be given to how the abuse suffered can compound the child's behaviour. Maltreatment of children who are disabled or have a chronic illness can be 'hidden in plain sight' (Franklin et al. 2022)[14], with the disability seen first and the possibility of abuse not considered.

22.5 Help-seeking or attention-needing behaviour is a fundamental skill for all children, it is a developmental skill that is essential for survival and needs support to develop; early experience of adversity, abuse and can have a negative effect.

22.6 Practitioners recognising, responding to, and validating the attention-needing behaviour of children and young people is essential. Research provides areas of practice that support finding out about 'the lived experience of the child' Some of the most salient ones which have also been highlighted in this review, are for practitioners to have:

- Professional curiosity: practitioners need to understand what is happening within a family rather than making assumptions or accepting things at face value. They need to ask questions and observe the child's surroundings.
- Respectful uncertainty: professionals must remain sceptical of the explanations, justifications, or excuses they may hear, and they should always 'check out' with other agencies and sources of information about what is being said. Professionals need to be attuned to the child's

[13] Dickens et al (2022a). Learning for the future: Final analysis of serious case reviews 2017-19. Department for Education

[14] Franklin, A., Toft,A., Hernon,J., Greenaway-Clarke & Goff,S. (2022) UK social work practice in safeguarding disabled children and young people: A qualitative systematic review. What works for Children's social care

world and pay attention not only to what the child says but also to what they are not saying. What is their behaviour communicating?

Recommendation 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.

23.0 IDENTIFYING AND ASSESSING THE RISK OF SEXUAL HARM

23.1 This review highlights the challenges professionals have, the complexities of working with child sexual abuse, and the importance of clarity regarding risk and need.

23.2 Gaps in multi-agency response to child sexual abuse within the family environment have been identified (JTAI 2020)[15]. The inquiry found that two-thirds of sexual abuse in children takes place within the family environment an estimated that only one in eight children in England who are sexually abused come to the attention of statutory authorities. Although Family H was not open to statutory authority there had been multi-agency involvement and a number of referrals to children's social care.

23.3 Identifying sexual abuse is hugely difficult as often no physical or medical evidence is present and children are unlikely to tell someone they are being abused, especially if the perpetrator is someone they know. Professionals rely too heavily on children making a disclosure and the Joint Targeted Area Inspection (JTAI) pinpointed four areas that could be improved when it came to identifying sexual abuse. These included ensuring all frontline professionals recognise the signs of abuse in the family and that they felt comfortable discussing it with all involved, with strong information-sharing protocols between agencies. The JTAI recommends better training, supervision, and support for frontline professionals.

23.4 Because of the difficulties children face in disclosing abuse to adults, their behaviour may be the key indication that something is amiss, this is true for both younger and older children. Children may be reluctant to disclose abuse, particularly sexual abuse through fear of not being believed or because they fear family breakdown. Some children display behaviours that may be indicative of abuse (e.g. aggressive, challenging, and sexualised behaviour), but these non-verbal signs are often missed or attributed to other causes, and a lack of curiosity about an alternative narrative.

23.5 Children with learning disabilities are at greater risk of abuse and may only display their distress through their behaviour. Disabled children are around

[15] Ofsted, CQC, HM Prison and Probation Service & HM Inspectorate of Constabulary and Fire and Rescue Services. (2020) the multi-agency response to child sexual abuse in the family environment Prevention, identification, protection, and support.

three times more likely than their non-disabled peers to be abused; they are also more likely to receive a poor response from professionals (Ofsted et al 2020). Professionals should not assume that challenging behaviour in a child with a learning disability is due to their underlying condition or parenting; it may be, but practitioners need to take a holistic approach that considers possible alternative causes.

23.6 The recent review of sexual abuse in the family environment has highlighted that there is not enough attention 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. Although the full facts of parental involvement remain under investigation in this case, regarding future cases where intrafamilial child sexual abuse is either identified or a concern, professionals need to consider the role of a non-abusing parent or extended family. It is critical that there is an assessment of the non-abusing parent's ability to protect and believe children.

23.7 It is also important to understand any vulnerabilities that can be exploited by an adult to make sexual abuse possible. Non-abusing parents may be groomed, making use of unmet needs for financial and emotional support or they may be coerced and controlled through domestic abuse. It was identified that parents worked for Adult 1 and lived nearby, therefore increasing the likelihood they could have been groomed by Adult 1 It is therefore crucial that the non-abusing parent has all the relevant information, and they understand the process of likely adult sexual offending to be equipped to address it. There is no evidence of parental understanding of the risk posed by Adult 1 and PA together, it was only evident that the parents were aware of Adult 1 not being allowed unsupervised contact with the children, this understanding of risk should be extended to wider family members who have care of the children.

23.8 It is evident from the agency report and discussion that the majority of the professionals involved with the family were not fully aware of the risks posed to the children by Adult 1 and PA. Furthermore, the motivation of PA's abuse is not known and she did not have an offending history of sexual abuse. The discussion at the practitioner event concluded there had not been any gender bias in this case as only Adult 1 had a history of sexual offending and PA had her children removed due to her poor parenting capacity. However, it is known she was vulnerable due to her learning difficulties, increasing her risk of coercive control and grooming. This was identified within the Adult Social Care report. Female perpetration of child sexual abuse has been a subject largely overlooked, females were more often involved with males in a co-offender situation, with male offenders perceived as both the initiator of the abuse and the aggressor and female offenders to be perceived as accomplices rather than an initiator. This may be in part related to some females' proclivity to make their victims available for abusive purposes. Women are usually responsible for

taking care of children which includes intimate tasks such as bathing and dressing, behaviour that may be sexually abusive can be more easily overlooked in the context of everyday childcare activities (West et al 2011)[16]. Thus, making sexual abuse difficult to discover and ultimately report to the authorities (Darling et al. 2018)[17].

23.9 Through discussion during the learning event it was highlighted there are an increased number of female perpetrators known to services, together with the recognition that professionals are also 'groomed' and the possibility of disguised compliance within the family, this reinforces the need for good supervision and peer support to obtain a reality check on their relationship with the family and multi-agency training to raise awareness of the themes highlighted in this review.

Recommendation 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.

24.0 SPECIFIC QUESTIONS FOR POLICE

24.1 The National Panel encouraged a specific focus for the police, the information was gained from their agency report the first focus was on Durham Constabulary's approach to:

i. **Recognising and assessing the risk of an offender, including the management and risk assessment of a young offender**:

24.2 The Police Agency Report States that risk management is at the forefront of everything Durham Constabulary does, with every incident and investigation being assessed on its own merit, victim-focused, and responded to accordingly. In this case, a variety of tools and methods were used. The Constabulary uses the National Decision Model THRIVE as the basis of all decision-making, this has been applied in this case throughout the incident/crime journey as it transitioned between departments. THRIVE assessments are recorded and incorporated into the audit and compliance processes.

24.3 The MASH triages all safeguarding forms that children are on and ensures the risk assessment is correctly graded using standard, medium, and high. Every safeguarding form is scrutinised using the safeguarding management tool, each form captures the eyes of the child/lived experience by mandated questions in every referral.

[16] West, S. G., Friedman, S. H., & Kim, K. D. (2011). Woman accused of sex offenses: A gender based comparison. Behavioural Sciences and the Law, 29(5), 728–740. https://doi.org/10.1002/ bsl.1007

[17] Darling, A. J., Hackett, S., & Jamie, K. (2018). Female sex offenders who abuse children whilst working in organisational contexts: Offending, conviction and sentencing. Journal of Sexual Aggression, 24(2), 196–214. https://doi.org/10.1080/13552600.2018.1476601

24.4 A child and family scrutiny panel is held monthly which examines 3 or 4 randomly selected incidents where children are involved. This can include those who have been in custody for sexual offences. The panel consists of police representatives from a range of departments and partner agencies. Each month the selected incidents are scrutinised to ensure the incident was dealt with in accordance with force policies and ensuring the safeguarding of vulnerable adults and children. Areas of good practice are identified and areas for improvement are also identified. Any themes for improvement that emerge over a 6-month period is fed into internal training/ awareness sessions.

24.5 For those offenders managed by the Public Protection Unit the Multi-agency public protection arrangements (MAPPA) are in place to manage the risks. The various agencies share information about offenders under MAPPA to assess the level of risk they pose to the public.

24.6 All forces apply the Risk Matrix 2000 (RM2000) model for risk assessment and the Active Risk Management System (ARMS) for dynamic risk assessment. Both are taken into consideration when creating an ARMS risk management plan. Chief officers and senior managers must ensure that MOSOVO officers are trained in the use of these tools.

24.7 Special considerations may apply to the management of young offenders. Research carried out by Victim Support found young offenders are particularly vulnerable to being harmed by others and becoming victims of crime. Depending on the young offender's age and circumstances, children's social care or local education authorities and/or special educational needs coordinators should be involved to ensure young offenders have their educational and other needs met. Children who are brought into custody would also be subject to the same police referral mechanism as other children and their needs assessed and information shared with partner agencies.

24.8 If a young person is in care, they remain the responsibility of Children's Social Care, although there should be dual case management with the Youth Offending Team (YOT) if a MAPPA referral is required.

24.9 Prior to April 2022 the threshold was not met for SHPO (Sexual Harm Prevention Order). However, at this point, the investigating officer could have discussed the case with the Public Protection Unit (PPU) and considered applying for a Sexual Risk Order (SRO) for both Adult 1 and PA. If they breached the SRO they could be charged, and the court would have the power to put them onto the sex offenders register and make them subject to a Sexual Harm Prevention Order. (SHPO).

24.10 A SRO is a civil order that can be sought where the defendant has done an act of a sexual nature as a result of which there is reasonable cause to believe that it is necessary for a Sexual Risk Order to be made. The suspect need not be convicted of any wrongdoing, or subject to a positive charging decision for the application to be made.

24.11 Recently Durham Constabulary has initiated further training on the use of civil orders. Continuous personal development includes training around civil orders. Additionally, this has been incorporated into the recent detective sergeants training covering SHPOs, SROs and potentially dangerous persons (PDP). PDP are people who, are not currently managed by probation (and therefore not subject to MAPPA) and have been identified as posing an 'imminent risk of causing serious harm'.

24.12 Durham Constabulary has Operation Chandler in place to monitor the use of Civil Orders, there are bi-monthly meetings and an action plan in place to monitor progress. Additionally, there was a Strategic/Specialist Civil Order Barrister Training Session took place on the 7th and 21st of July 2023. The sessions involved input from three barristers to raise awareness of the use of civil orders across the force.

ii. Understanding of familial relationships and potential access to children:

24.13 Durham Constabulary recognises that intra-familial/familial child abuse occurs within a family/home environment. Recent training delivered to officers recognised that consideration needs to be given in cases where the abuser is family or feels like family from the child's point of view and is not. Perpetrators may or may not be related to the child.

24.14 Training delivered also summarises a holistic view of the issues occurring within families and their ensuing detrimental effects. Recognising that familial harm is the damage caused by adverse circumstances, (ACES) vulnerabilities, and/or negative behaviours that often lead to long-term negative consequences.

24.15 Furthermore, the training delivered across the force uses examples of intrafamilial/familial relationships and the risks they can pose. When delivering child abuse training to new recruits, examples are given of case reviews whereby intrafamilial abuse has taken place. Examples of female and male offenders are also discussed to stress the importance of not being gender biased.

24.16 As a result of a change in process, the digital forensic unit now looks at intrafamilial/familial harm when they triage devices. Nevertheless, there is a reliance on investigating officers to accurately record the family links on systems and the LIMA (Digital Forensics Unit Portal) form submitted. The Sergeant within the Digital Investigation Unit reviews the reports to ensure they adequately capture the associated risks.

iii. Fast tracking of digital devices for forensic examination.

24.17 County Durham Constabulary has a digital forensics unit (DFU) which is responsible for the downloads of electronic equipment. In this department, staff work to a service level agreement that is 9 months for standard risk cases and 14 days for high-risk cases for work to commence. The service level

agreement forms part of ISO accreditation standards and is subject to regular inspection by the United Kingdom Accreditation Service (UKAS).

24.18 At the time of Adult 1 and PA's arrest in April 2022, a LIMA form was submitted to request an examination of the electronic devices. Despite this being completed very promptly and only the day after the investigation commenced, the information on this report was basic and the THRIVE did not mention the previous offending history. Hence, the outcome of triage was the case remained as a standard risk case and no priority was given. The lack of information recorded was a concern as the team is reliant on this and any other identified potential risks. In April 2022, the team would only look at what was recorded on the form and not check other systems routinely due to capacity though this has since changed.

24.19 There was a further short delay due to the way the devices were packaged. This caused a delay of 2-3 working days whilst this issue was resolved, and feedback was provided to the officers who had made the seizures.

24.20 Since November 2022 an experienced sergeant has been positioned in the digital forensic unit as lab manager to review the submissions on LIMA, risk assess, and prioritise work accordingly. Changes made to LIMA have allowed for a greater understanding of risk relating to the submission, coupled with a review by an experienced police sergeant assigning internal priority from 1 to 5. The highest end of the scale is homicide/stranger rape/public protection unit remand cases which are downloaded immediately.

24.21 Additionally, there has been an uplift of staff in the DFU and wider digital teams within DIU. This is supporting demand, and the DFU manager actively monitors all submissions, promptly returning any submission queries to the investigating officer to rectify if required.

25.0 RECOMMENDATIONS

1a. 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.