Dudley Safeguarding People Partnership

Local Child Safeguarding Practice Review

Safeguarding children when there are adults in the family who pose a sexual risk

Agreed by the partnership: 13.09.2022

Independent Lead Reviewer: Nicki Pettitt

Contents

1 Introduction

1.1 The DSPP agreed to undertake a local child safeguarding practice review (CSPR) which considers professional practice with a family that includes adults who pose a sexual risk to children. The partnership recognised that lessons could be learned from reviewing this case.

1.2 Three siblings are being considered, but there are many more children and vulnerable young adults in the wider family who could be at risk from the dangerous adults. The report will refer to Child 1, a girl aged 6. Children 2 and 3 are her brothers aged 7 and 8.

1.3 There are at least two known sex offenders in the family. They are the children's grandfather and their grandmother's then partner. In October 2021 the children's aunt made allegation of child sexual abuse from her father (the children's grandfather). He has been convicted and is serving a prison sentence. There were concerns at the time that the children's mother had tried to persuade her sister drop the charges about the alleged abuse, that the children were having contact with both risky adult men, and that their mother had limited insight into the risk they may pose to her children.

1.4 The children were initially placed with their grandmother, but when concerns emerged about this arrangement, they were placed in foster care. Child 1 then had several placements breakdown and spent the Christmas period in hospital.

1.5 The children are of mixed parentage white and black African and Caribbean. They had no contact with their father/s[1] who did not have legal Parental Responsibility for the children at the time.

1.6 Learning has been identified in the following areas:

- Information sharing about risky adults with all those working with or responsible for the children, including the children's parent/s
- Awareness of the likelihood that the children, family members and professionals may have been groomed
- If there is no conviction for offences against children, there is a need to seek, share and consider other available evidence of sexual abuse
- When the procedure for organised and complex abuse should be used, to include mapping in large and complex families

[1] The children's social worker has attempted to contact them during the care proceedings. They were successful in only one case. However, he has now left the country and has not responded to further contact from CSC.

- The need for curiosity about a child's behaviour which includes the consideration of sexual abuse

2 The Process

2.1 An independent lead reviewer was commissioned[2] to work alongside local professionals to undertake the review. Information provided to the Rapid Review meeting was considered and individual agency chronologies including reflection and analysis were requested from all involved. These identified important single agency learning and made single agency action plans.

2.2 Professionals involved at the time were involved in discussions about the case and the wider system, with a face-to-face practitioner participation session held in May 2022.

2.3 A panel of safeguarding managers from the relevant agencies worked with the lead reviewer to ensure effective and achievable improvement actions were made.

2.4 The lead reviewer and a representative of the DSPP met with both mother and grandmother, and the report includes reflection on what they had to say. learning from their perspective.

3 The Learning,

3.1 The learning identified for the safeguarding system and partnership is as follows:

Learning point 1: When there are adults in a family who may pose a sexual risk to children, it is essential that all the professionals working with the children in the family are aware of this.

3.2 The children's grandfather has many children and grandchildren, there are also a lot of children in the wider family who were vulnerable and potentially at risk from him. One of his nieces made allegations that he sexually abused her while she was a child for example. Information sharing is essential in these circumstances, along with an awareness of all of those who are vulnerable. Much of the information about the family was only shared during this review, and there was evidence of several children in the family being worked with in isolation, without consideration of the wider risk, including to the children in the family being considered in this CSPR.

3.3 It is evident that several of the professionals involved with the children in this family had no understanding about the wider context of risk within the family. It was not a straightforward case, with many children across generations of the wider family potentially having contact with the grandfather. His actual convictions for sexual offences were in respect of adult family members, although many of the allegations made were about the sexual abuse occurring or starting when the victims were children and there was other information available that pointed to him being a serious risk to children.

3.4 The review found examples of professional engagements with the children that may have been seen as significant had the background information on the risk in the wider family been available. For example, the GP may have been more concerned about urinary tract infections that the children had, and the children's health visitor may have been curious about information that was shared from the hospital about

[2] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is a lead reviewer undertaking Serious Case Reviews and now Child Safeguarding Practice Reviews and is entirely independent of the DSPP.

one of the boys having inflammation around his penis and anus[3] in 2016. A piece of information about a child can be more concerning than it appears superficially, depending on the wider context.

3.5 It was clear that some professionals, including those working in the Multi-Agency Safeguarding Hub (MASH), were aware of the concerns about the grandfather, but they were not entirely sure of the scope of his contact with children. This was partly due to the information system used that refers to adults by a PIN number rather than their name, which can lead to depersonalisation and hinder a narrative of information and intelligence about a person who poses a risk. It is also noted that it was previous practice to include information about a person posing a risk to a child into the child's CSC record without ensuring that the adult's record also included the referral information. Clearer and more robust processes are now in place due to a new CSC information system and work by Dudley Council on how PPRC[4] notifications are responded to.

3.6 The grandfather is well known to the police and to probation and he is on the sex offenders register with lifetime registration requirements. While he was appropriately managed as part of this requirement, the risk he posed was not more widely shared or known by professionals working with family members, including children. Practitioners said during the review that reductions in police officers may have had an impact, particularly neighbourhood officers who would potentially be aware of adults who pose a risk and could provide some degree of informal monitoring. However, it is acknowledged that this is not a required role for the police and other demands on the service are likely to take precedence.

3.7 The review has found that a lack of early information sharing with professionals working locally, such as the children's GPs[5], allowed the risk posed by their grandfather to be largely undetected and for there to be limited evidence known and shared of his contact with children. There is the potential for more effective monitoring of risky adults in neighbourhoods using the Safer Estates meetings, to discuss intelligence and activity in the area, but this requires information to be known and the ability to share it. The MAPPA (multi-agency public protection arrangements) meetings often considered the grandfather's apparent contact with another child in the wider family and had a role in deciding what information can be shared and with who, with the chair making this decision during every meeting. It has been agreed that the learning from this review needs to be shared with those responsible for the West Midlands MAPPA processes to ensure that they note the identified need to share information about risky adults more widely within families such as this one. A recommendation has been made.

3.8 Probation staff suspected that the grandfather was having contact with several children but could not prove this. The grandfather had extensive experience of the criminal justice system and was largely able to avoid detection. For example, he used his reported health concerns to avoid the polygraph testing that was part of his licence. Probation was swift to recall him to prison when information did emerge of him having contact with one of his younger children however, which was good practice. This case clearly

[3] Balanoposthitis
[4] Person posing a risk to children
[5] In this case the grandfather was registered with a different GP to the children in the wider family, and that GP was not aware of the risk he posed or of the number of children within the family.

shows the need to seek and consider information held by agencies such as probation when making assessments and plans for children where there is a risk of intra-familial sexual abuse.

3.9 Those involved were able to reflect on the obstacles to information sharing in a case like this. The fact that the criminal convictions were for sexual assaults on adults rather than children created concerns about sharing information with those working with children in the family. There had been many allegations made by children, but for several reasons they had not led to an actual conviction. Those involved had been believed however, and it is acknowledged by professionals that there was enough evidence to believe he posed a serious risk. For example, the family widely acknowledged that the children's grandmother became pregnant with their mother when she was 12 years old, and grandfather was 26. This alone was enough information for the threshold to be met for a child protection response when there were concerns about him having contact with children in the family or community.

3.10 There was more recent information that also needed to be considered. The social worker with responsibility for some of the grandfather's other children undertook an assessment early in 2019 which concluded that the children would be placed at imminent risk of significant harm of sexual and physical abuse perpetrated by their father if they were to have contact. This information was not sufficiently considered in respect of other children in the family, including the children being considered by this review.

Learning point 2: When assessing the ability of a parent to protect their children from a risky adult in the wider family, there needs to be an understanding of the relationship, contact and whether the adults, as well as the children, have been groomed.

3.11 On the occasions that the risk posed by her father was discussed with the children's mother, she insisted that while she had contact (including visiting him regularly when he was in prison) the children did not. She was plausible and came across as protective, although no assessment had been completed in respect of this. When her consent was requested to undertake assessments, she always refused, stating there was no reason to be concerned. This was largely accepted by professionals. It was also significant that the mother worked as a carer and was always keen to stress that she had undertaken safeguarding training and that she understood why she needed to ensure that her children were protected. This was not rigorously challenged until after her arrest in 2021. The mother was also proficient at avoiding professionals and she would not engage in difficult conversations about her father and her own history of abuse. It was only after the children were removed that information came to light that she too may have been sexually and emotionally abused by her father, although she continues to deny this.

3.12 There was evidence that the children in the family were under pressure to ensure that any contact they were having with their grandfather was not disclosed to professionals, which would have been emotionally harmful to them, as well as placing them at risk of sexual harm. The children clearly presented as being coached about what to say and how to behave. After the school had a conversation with the mother, Child 2 went to school and stated, without being asked and entirely out of context, that he never spent time with his grandad. It was only after they had spent some weeks in care that the children confirmed that they had in fact had significant contact with him.

3.13 The grandfather himself was seen as a powerful individual both within his family and in his local community. He has a reputation for violence and intimidation. Anger, aggression, and the threat of violence is a powerful grooming technique, as it makes the victim of any type of abuse less likely to disclose what is happening. Perpetrators of sexual abuse are known to groom children, family members and professionals, and being a menacing individual can keep people from asking too many questions as well as keeping victims quiet. The risks posed by the grandfather went beyond sexual abuse and there are wider concerns about criminality, which added to the intimidation.

3.14 As well as invoking fear, perpetrators of sexual abuse are also known to work hard to gain the trust of children, their families, and even professionals. Or they can avoid engagement, create diversions, or undermine the professional and the process. Abusers can also present as vulnerable, state that everyone is against them, and can blame the child/victim. It is often the case that the family or the child can have a dependency on the offender, which impacts on the ability of the parent to protect their children. The grandfather in this case presents as more affluent than most of his family and it is thought that he uses money and the properties he rents out to family members as a hold over them and to instill loyalty.

3.15 It can therefore be difficult for professionals to identify a perpetrator. Working with families where child sex abuse is an issue is complex and difficult work and it requires specialist support and supervision, including to determine if professionals are themselves being groomed. A Joint Agency Targeted Inspection (JATi) was undertaken and published in February 2020 to consider how professionals worked together in cases of intrafamilial sexual abuse in a national sample of local authority areas.[6] The JATI concluded that professionals must have an awareness of how sexual offenders operate. They found that '*front line professionals are not equipped to know enough about perpetrators of child sexual abuse in the family environment: how to identify them, what their escalation patterns are and how to prevent them from abusing children'.* When considering this case, the cases of children in the wider family, and the anecdotal information shared at the professional's event, it appears that this is also the case in Dudley.

Learning point 3: If there is no conviction for child sex abuse, there can still be a risk to children from an individual of concern

3.16 It was significant that the grandfather's convictions were not for sexually abusing children, although there had been numerous allegations and assessments that concluded he was a clear risk. It is apparent that there were also other adults in the family that needed to be considered as potentially posing a risk to children at the time. In April 2019 it emerged, after the police visited the home due to concerns about a dog, that the children's grandmother had a new partner who was a sex offender and who appeared to know the children well. Again, the fact that his offences were against an adult, and not a child, led to a MASH decision to take no further action after attempts to speak to the children's mother were unsuccessful. This decision appears to have been made without considering the presence in the family of two sex offenders, the pattern of the children's grandmother's relationships with sexually abusive men, and what this might mean for the children who spent a lot of time in her care.

[6] Multi-agency response to child sexual abuse in the family environment: joint targeted area inspections (JTAIs) 4 February 2020

3.17 Around the same time, two teenage siblings of mother's were living with her and the three children in the family home. Both sisters had recently reinstated contact with the family after being removed as young children. They were known to be vulnerable and at high risk of CSE. While there was work undertaken in respect of the two young women and concerns about their relationship with their father (the children's grandfather), there was no focus on the children being considered by this review, either in respect of the impact on their care of the change in family situation, but also on the ability of their mother to protect them from their grandfather when there was evidence that she was actively supporting her sisters having contact with him. The professionals involved did not consider the unthinkable - that the children's mother may be actively involved in allowing her father access to children for the purpose of abusing them.

3.18 In October 2019 there was a further opportunity to consider the lived experience of the children when Child 3 was seen at the hospital having allegedly been physically assaulted by his mother's 19-year-old brother who was reported by the family to have has learning difficulties. The MASH established the existence of risky adults and vulnerable young people in the family. Checks were undertaken and it was established that the school had no concerns about any of the children. This, and the fact that the mother had sought medical advice, led to the conclusion that she was most-likely protective. There were challenges in contacting her however, and when the social worker who was undertaking the assessment spoke to her to request consent for the assessment, the mother refused but agreed to stop any contact between her children and their uncle. This incident was considered in isolation from the wider concerns in the family about the grandfather, grandmother's partner, and mother's sisters and the risk they may pose. There was also information shared that the perpetrator may not in fact be the uncle that was not pursued at the time, due to the children's mother not being candid. Although the link with the grandfather was established and recorded on the case notes at this time, I.T. system links were not placed on the CSC records[7] across the wider family.

3.19 The children were closed to CSC following the consideration of the above single incident and immediate family issues rather than gaining a full understanding of the family links / relationships and contact with concerning adults. This case clearly shows the risk and disadvantages of undertaking assessments based on a nuclear family, rather than looking at the wider context. When there is a perpetrator who is a risk to children across the wider family, children at risk can be missed and information may not be easily available for consideration by those working with them. In this case there was CSC involvement with the younger children of the grandfather and concerns about the risk to them of sexual abuse. Work with that part of the family was undertaken in isolation from the other children in the family, or indeed the community.

3.20 There is no evidence that a genogram and/or an ecogram were used and shared with the agencies involved to consider the children's relationships with their extended family members. Such tools are an important part of any assessment. They are helpful tool when speaking to parents and children, as they help the professional to understand relationships and family dynamics and can provide a helpful understanding of a child's lived experience. For processes like the MAPPA, creating a multi-agency

[7] This was prior to Dudley Children's Services commission of a new electronic case recording system (Liquid Logic) in November 2020. The new system is a more effective. It allows case note alerts and easier linking of relationships.

detailed genogram for consideration at MAPPA meetings is essential. This needs to be reviewed and added to over time and shared with and considered by all partner agencies.

3.21 It is important for information to be shared, sought, considered, and carefully recorded when working with a family as complex as this one. Grandfather was recalled to prison in November 2019 as he had been discovered to be having contact with one of his children. This was discussed at a MAPPA the following month and while information was added to the CSC file for the child that had been observed at his house, it was not added more widely to the records of children within the family, such as those being considered by this review. Again, in January 2020 when one of the teenage sisters of mother told her social worker she was looking after the three children while their mother visited grandfather in prison, this was added to the teenage sisters CSC case record but not to that of the three children. The same young woman's adoptive mother shared concerns with Barnardo's about the children's mother allowing people to visit her and the children at home during the first COVID19 lockdown. This was despite one of the children apparently[8] having a health condition that would make him more susceptible to serious illness should have get Covid. No action was taken as the referral was made without consent and was not considered a safeguarding matter. The decision not to pursue this matter was made in the very early stages of the COVID 19 Pandemic, although the review was told that this did not have an impact on the decision. It would have been an opportunity to consider the relationships in the family and the children's lived experience at a time where the children were potentially particularly vulnerable, had consent been sought and granted or if it had been seen as a safeguarding issue.

3.22 The children's mother told the review that she was not aware at the time of the extent of her father's history and the concerns that were knowable to the professionals at the time. Now she knows the extent of the concerns she recognises that she was groomed by her father, and how successful he had been in undermining the information that was shared with her. Her father had not been in her life when she was a child, and she was desperate to have a relationship with him. She is adamant that the children did not spend anytime alone with him however. At the time, a professional understanding of the need to seek and then transparently sharing the risks, while acknowledging the likelihood of grooming, would have been helpful.

Learning point 4: Child protection procedures need to be used when information is shared that a person of concern is having contact with children. If a large family across several households appear to be at risk, consideration should be given to using the procedure for organised and complex abuse [9]

3.23 The reflective event for all the professionals who have worked with the family was the first time that they had an opportunity to consider what was known at the time across agencies. In this case the removal of the children under police protection powers was not followed by an initial child protection conference (ICPC) at the time, as is often the case. An ICPC is usually the place where a family history is shared in a multiagency context. This can mean that this important information is not shared when care proceedings

[8] This condition is not in fact of concern and the mother appears to have used it as an excuse to avoid professionals and scrutiny during the pandemic. The school and CSC accepted what she stated, despite there being no evidence of this as a health concern.
[9] https://westmidlands.procedures.org.uk/ykpzp/statutory-child-protection-procedures/organised-and-complex-abuse

mean a conference is not required. Consideration had been given to a conference being held in respect of the three children following their mother's arrest, and it was initially agreed that one should be held. However, following a Significant Harm Checklist threshold discussion[10] between the social work team manager and the duty child protection conference chair (CPCC), a conference was not arranged. The discussion included reflection on the lack of evidence at the time that the children had been exposed to sexual abuse, the belief that the grandfather's offences were in respect of adults, the fact that he was currently held in prison following the allegations, and police decision that the children be placed with their MGM. The role of the CPCC in the threshold discussions is to provide advice, but the decision regarding whether to go ahead with a conference is that of the social work team manager. The view of the CPCC in this case was that it made sense to undertake a full assessment to determine whether the threshold for a CP plan was likely to be met, and the team manager agreed. The children remained living with their grandmother with the agreement of their mother as a family arrangement under S17[11] (child in need).

3.24 Over the weeks that followed, the police shared intelligence of concern regarding the grandmother and her household, and at a MAPPA meeting CSC were directly challenged about the decision not to hold an ICPC in respect of the three children. This resulted in a strategy meeting where enough concerning information was shared to ensure that an ICPC was called along with the decision that the local authority should seek legal advice in respect of the children. The presence at this meeting of probation and the prison offender manager was good practice and the information they shared ensured that the risk grandfather posed, and the control he continued to have, even from prison, was recognised as significant. A discussion was held with Dudley Legal Services who advised at this stage that the threshold criteria had not been met. This advice does not appear to have taken into consideration the concerns about grandmother's ability to safeguard the children, that their mother was refusing to agree to S20. There was also insufficient understanding of the intragenerational coercive control and grooming involved in the family that is such a significant part of intrafamilial sexual abuse**.**

3.25 In contrast to the lack of concerns earlier in the year, the children's school had been reporting serious concerns about 5-year-old Child 1's behaviour, and it emerged that she had been on a part time timetable for several months. Although there had been some improvements since her grandfather had been in prison and she had been living with her grandmother, the reports of her continued 'defiance, tantrums, hurting people, upturning tables, and throwing chairs' were of concern. A change of social worker at this time led to an in-depth assessment of the family history and culture which included both the mother and grandmother. There were also visits to the children at school and it was apparent that they had had extensive contact with their grandfather when he was not in prison. Information that had been known previously was reshared at this stage about grandmother's partners sexual offending, and it was agreed the children could not remain in her care.

3.26 A formal viability assessment was completed over the next few weeks which confirmed this decision. The time required to undertake the assessment resulted in a delay in applying to the court to remove the

[10] A positive process that happens in Dudley as a way of reflecting on cases prior to a conference being called, as there was felt to be a disproportionate number of cases coming to conference that did not meet the threshold for significant harm at the time.
[11] Children Act 1989

children. This delay tends to happen when there is the possibility of a family arrangement which could avoid the need for court proceedings. In this case, with the wider concerns within the family and the information available about the MGM and her partner, court proceedings were likely inevitable. On the day that the order was gained, and the children were removed, there was a very difficult scene at the family home which upset the children, the family, the community and was extremely difficult for the professionals involved. CSC have reflected on this and identified learning in respect of the planning for and timing of removal and placement choice, as the proximity to family members led to a need for a later change of placement for the children. A further strategy meeting and risk assessments would have helped to ensure that the removal of the children was formally discussed with partner agencies and a multi-agency plan made.

3.27 While the children were in foster care there continued to be concerns about the reach of the family. Advances in gaming software means that the whereabouts of children can be located when they are playing games such as Fortnite on Nintendo Switch. This is a wider safeguarding issue that emerged in this case when family members established the addresses of the children's placements. The children were regularly talking to family members, including their mother, outside of planned contact via their electronic games. There is a lot of advice available for parents regarding game content, the possibility of bullying during communication in a game, and the risk of a child being contacted by people they don't know and potentially groomed or exploited. The impact on children in care who should not be having contact with family members has not been widely explored or publicised, although there is helpful advice about this as a specific issue that carers need to consider for children in care from the National Fostering Association[12]. Considering the practice implications of understanding and monitoring a child's access to phones, social media, and games to ensure that children are not continuing to be groomed and abused while in care is required both locally and nationally. This should include awareness raising for all professionals and carers with very regular updates. A recommendation has been made regarding this issue, which is of national importance and not just specific to Dudley.

3.28 There were serious difficulties in finding a new placement for Child 1 due to the reports of her extremely distressed behaviour in school and in her first foster placement. Learning has been identified about the need to ensure that placement forms include honest information about a child but that it is trauma informed and reflects the child's difficult experiences. The school continued to provide just 90 minutes education in school a day for Child 1, which put pressure on her existing placement, increased the difficulty in finding a new placement, and led to increased pressure on Child 1 herself. The school told the review that they understood the need for Child 1 to be managed in school for longer than 90 minutes a day but felt they did not have the experience or systems to contain her anger and enable her to build emotional self-regulation. Their view was that she required expert intervention that could not be provided in a mainstream setting. It has been acknowledged that an urgent PEP meeting was required along with the involvement of the Virtual School and early years managers. The school needed to be proactive in ensuring Child 1's needs were assessed and met, as much of the professional energy and worry at the time, particularly for CSC staff, was in respect of needing to find new placements for the children and

[12] https://www.nfa.co.uk/story/story_category/keeping-children-safe-online-a-foster-carers-guide-to-internet-safety/#onlinerisks

concern about keeping them safe when family members were aware of their location. Managing contact with the children's mother was particularly difficult, and the children were agitated and unruly during the sessions and afterwards when they returned to their placements. There was an acceptance of the school's view and position without the required challenge.

3.29 In the month following her removal from her mother's care, Child 1 had three different placements, the last of which was respite while a longer-term plan was made. There was a lot of professional concern about the extreme distress being shown by such a young child, and a degree of uncertainty about making a plan that would meet her needs. The third placement broke down on Christmas Eve, with the carers calling an ambulance stating that they were unable to transport her to hospital for a planned health check, due to the level of distress she was showing. This led to Child 1 spending Christmas in hospital as a new placement that would meet her needs could not be found. There had been extensive efforts and large budgets allocated to support the placements and to source a suitable new placement. Over the Christmas period an extensive package of support was provided by CSC to Child 1 on the ward, and she received 24/7 one to one support.

Learning Point 5: It can be difficult to safeguard children when they do not make explicit allegations of sexual abuse. Professionals need to be curious about a child's behaviour and robustly consider other indicators that they may be a victim of sexual abuse.

3.30 Those involved with the children being considered and with many other children across the family recognised that the grandfather posed a risk but struggled to be clear about what they could do, as none of the children they were working with had made any allegations. Protecting children from child sex abuse is complex, as children are unlikely to make an outright disclosure of what has happened. For sexual abuse to be obvious to professionals either because they make an allegation or through a child's behaviour, the abuse has already happened. Working preventatively is a challenge. Professionals need to look for signs and indicators of abusive behaviour and identify contexts where children may be more vulnerable to sexual abuse, as was the case here.

3.31 The systems in which professionals work creates an over-reliance on a child disclosing sexual abuse, yet evidence shows that a child is unlikely to make an allegation, particularly when the perpetrator lives with them or is a close associate of the family. Seven years ago, the Children's Commissioner carried out an inquiry into child sexual abuse in the family environment. The report[13] stated that only around one in eight children who are sexually abused are identified by professionals, and while the police and local authorities recorded around 50,000 cases of sexual abuse over the two years to March 2014, it is estimated that as many as 450,000 children were abused over the same period. It is an on-going challenge across the UK for professionals to identify children who are at risk of or who have likely suffered sexual abuse.

3.32 Even when a child has made a disclosure it is not always easy for the perpetrator to be successfully prosecuted. The children's grandfather has been the suspect in many child sex abuse investigations. At

[13] Protecting children from harm: A critical assessment of child sexual abuse in the family network in England. The Children's Commissioner.

no point has he been convicted, although his convictions are serious and many of the victims allege the abuse started when they were children. Those involved reflected that it can be easier to get a conviction for a sexual offense against an adult than against a child. There were also other child protection investigations where it was decided that the evidential threshold for a criminal conviction may not be met, but where it was agreed on balance that it was likely that the grandfather had sexually abused the children who made allegations. The ages of the children in this family likely created a further obstacle, as it is known that children often do not recognise that they have been abused until they are older.

3.33 As so few children are likely to make a disclosure, professional curiosity alongside an understanding that sexual abuse does happen and will likely have an impact on a child's behaviour is essential. Those who know Child 1 well believe that her extreme behaviour is a response to having experienced trauma. What that trauma was has yet to be determined. It is known that she had unsupervised contact with her grandfather and her grandmother's partner, and that her mother allowed her to be exposed to this risk.

3.34 It is not entirely straightforward to determine that a child has been sexually abused even when they are displaying extreme behaviour as was the case with Child 1. There are often other potential reasons for a child's behaviour. In the case of Child 1 there was a view that her behaviour may have been learned or copied. A teenage sibling of her mother's had spent time living with the family and had exhibited difficult behaviour while there. For a five-year-old to show such extreme distress is unusual however and it was important to consider all potential reasons, including recent or ongoing trauma. The 2020 NSPCC report Child Sexual Abuse: Learning from Case Reviews[14] states that '*if professionals are not continually challenging and curious about the source of children's distress, this can lead to missed opportunities to recognise and stop sexual abuse'*. It is known from the same report that *'between a half to four fifths of children and young people who report sexual abuse have some symptoms of post-traumatic stress disorder (PTSD), anxiety or depression, and many exhibit self-destructive behaviours.'* Professionals need to be alert to this, even in the youngest children, as this case shows. They also need the knowledge to understand the research and available knowledge about sexual abuse in the family environment.

3.35 As well as the risk of the sexual abuse of a child, there is an additional emotional risk to children who live in a family where sexual abuse occurs and is accepted, as appears to be the case in this family. For professionals to consider and challenge families about the lived experience of the children in their households, there needs to be an agreed process for assessing and working with families, with tools that professionals can use. In Dudley learning was identified in respect of a review on an older child who had been the victim of sexual abuse through exploitation, and it was agreed that the use of tools such as the Brook Sexual Behaviour Toolkit[15] were particularly effective for professionals with concerns. Consideration needs to be given to how to use this type of approach with younger children, including the use of the NSPCC PANTS Guidance[16]. The CSA Centre's Signs and Indicators Template which helps professionals gather the wider signs and indicators of sexual abuse to build a picture of their concerns[17]

[14] NSPCC. Published January 2020
[15] https://www.brook.org.uk/training/wider-professional-training/sexual-behaviours-traffic-light-tool/
[16] https://www.nspcc.org.uk/keeping-children-safe/support-for-parents/pants-underwear-rule/pants-guides?utm_source=Adestra&utm_medium=email&utm_content=Access%20the%20guides&utm_campaign=20220721_KIS_New-in-the-Library-external_July#
[17] https://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/signs-indicators-template/

also requires consideration. A recommendation has been made in respect of the need to improve professional knowledge and practice about children who are likely to have been exposed to sexual abuse.

4 Conclusion and recommendations

4.1 It Is not known if the children in the family being considered have been sexually abused, but learning has been identified regarding how information was shared and the need for professionals to understand the way that children and their carers may be groomed by those who sexually abuse. The extent of child sex abuse in our society means that all professionals should have an open mind about whether sexual abuse could be an issue in any family they work with. They must understand that sexual abuse can happen to very young children, to boys as well as girls, to disabled children, to children from all ethnic, cultural and religious backgrounds, and that it is often perpetrated by close family members.

4.2 All partner agencies need to encourage reflective practice and supervision that encourages professionals to think about sexual abuse. The opportunity should also be taken to ensure that information about the extent and signs of intrafamilial sexual abuse is widely shared across professional networks. As stated in the 2020 JATi, *'local area leaders across all agencies must provide better training and support for frontline professionals on the issue of sexual abuse in the family environment.'* There is also an identified need in a complex case like this for the professionals involved to take advice from a specialist regarding intrafamilial sexual abuse and the potential for the sexual abuse of children in the family, and consideration of using the complex and organised abuse procedure to map the extent and reach of a perpetrator's potential to abuse. The review does recognise however the impact that a lack of capacity and stretched resources locally and nationally has on the services that need to respond to the risk of sexual abuse.

4.3 Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. There has been excellent cooperation with this review from partner agencies, which was essential in establishing the learning from this case and providing the professionals involved in this difficult case with the opportunity to reflect.

4.4 Having considered the learning from this review that has not been addressed in the single agency actions, the following additional recommendations are made to ensure improvement actions are taken.

Recommendation 1:

The Partnership to seek assurance about the use of the complex and organised abuse procedures in cases where there is a risk of child sexual abuse in the wider family from a dangerous adult/s

Recommendation 2:

The Partnership to ask the national CSPR panel to consult with the government regarding whether the risk to children in care of technology being used to locate and contact them can be included for consideration in the Online Harm Bill currently going through parliament. In the meantime, the Partnership needs to ask local agencies to consider how they can ensure that the relevant professionals and carers of children in care are aware of this risk

Recommendation 3:

The partnership to request that agencies consider how they can improve professional awareness and practice in respect of:

- how perpetrators may conceal their abuse
- how a non-abusing parent/carer may be complicit or unaware of abuse
- how to work with children when they do not disclose abuse but are likely to have been exposed to child sex abuse

Recommendation 4:

That the learning from this review is shared with the West Midlands MAPPA coordinator and the West Midlands Probation Head of Public Protection. A request should be made that information about risky adults in families such as this is shared widely via the MAPPA process, and for assurance to be provided that this will now happen