

Pan-Dorset Safeguarding Children Partnership



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Local Child Safeguarding Practice Review

Thematic Summary: Intra-Familial Child Sexual Abuse

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1.Introduction

This Child Safeguarding Practice Review (CSPR) is concerned with the sexual abuse of children in their families. Following a Rapid Review in November 2020 and in consultation with the National Panel¹, Pan-Dorset Safeguarding Children Partnership (P-DSCP) decided to undertake a thematic local child safeguarding practice review (LCSPR). This CSPR considers all the enquiry points raised in the Rapid Review. The Report provides a compendium of key learning and recommendations for practice and system change in a manner which ensures the rights and protection of the children involved. It is written with the intention of publication and as such does not contain any details of accounts or information which may identify individual children or adults. The detailed analysis with evidence to support this Report has been shared across agencies and is now held by P-DSCP. The Review has ensured a collaborative approach with family members and a range of professionals across the Partnership in Pan-Dorset.

We do not know how many children experience this type of harm as more often it is hidden from view, although the data tends to tell us 1 in 20 children in the UK have been sexually abused, the vast majority by someone they knew². Much child sexual abuse in the family remains unspoken of and there are many well cited reasons for this³, often due to the traumatic nature of this type of abuse as it typically involves high degrees of betrayal, manipulation, stigma, and secrecy. It is also considered that child sexual abuse in the family is rarely an isolated occurrence and may go on for many years and for multiple children. According to the prevalence statistics this type of abuse is specific to gender with 20-36% of girls thought to be sexually abused in childhood, although again these statistics are likely to be under-estimated⁴. Research⁵ finds most adults who cause sexual harm are male, although abuse by women does occur.

Consideration of culture and identity

Dorset is a largely rural unitary local authority in the Southwest of England with a population of around 375,000; 28% of whom are aged 65 and older. Dorset has far fewer black and ethnic minority residents than the rest of the UK with 4.4.% of the population describing themselves as ethnically diverse⁶. This thematic summary considers a family who identify with a white British culture. Currently in Dorset over 90% of children requiring child protection plans are identified as white British. Research tells us that levels of CSA do not vary significantly with social class or ethnic group, but children from Black, Asian and minority ethnic backgrounds are under-represented in official reporting of service use relating to CSA.⁷

A note about the importance of written and spoken language: the words we use and the way we talk about intra-familial child sexual abuse actively influences the way we think about, talk

¹ The Child Safeguarding Practice Review Panel is an independent panel commissioning reviews of serious child safeguarding cases Children and Social Work Act 2017

² NSPCC Child Sexual Abuse: statistics briefing March 2021

³ NSPCC Child Sexual Abuse: statistics briefing March 2021

⁴ Why are Women Blamed for Everything; Exposing the Culture of Victim-Blaming, Dr Jessica Taylor, 15 April 2020; Little, Brown Book Group

⁵ See Centre of expertise on Child Sexual Abuse

⁶ Dorset County Council's Diversity Report 2021

⁷ Sexual abuse of Black, Asian and minority ethnic children and young people: "People don't talk about it". Centre for expertise on CSA, October 2020

about, and arguably act. The acronym CSA is used throughout and refers to all forms of child sexual abuse as defined in Working Together⁸. The term intra-familial child sexual abuse (IFCSA) refers to sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member⁹. Within this definition, the adult may be close to the child, such as a father, uncle, or stepfather. As in line with much research¹⁰, a choice has been made to use other words than “*victim*” to describe the child who has experienced the harm; “*disclosure*” to explain when a child tells of the abuse and an adult who is thought or known to have abused is chosen over the word “*perpetrator*”.

2. What the Review looked at and found

The Review considered:

- Children and parents’ perspectives and the impact of sexual harm
- Complexity of assessing and understanding the protective abilities and dynamics within the family
- Understanding historical factors and indicators when assessing intra-familial child sexual abuse
- What helps and hinders children in telling someone when they are or may be at risk of sexual abuse
- How individual agencies and the safeguarding system identify and respond to intra-familial child sexual abuse in families
- The role of legal safeguarding orders

The Review examines practice and systems in Dorset from March 2019 until October 2020 with a critical eye on contextual factors known by statutory agencies prior to this. Understanding what has happened in families over time is important work when assessing current risk factors, risk indicators and protective factors. The cumulation and interaction of these factors help professionals understand how safe children are in their families and the Review sees how this was often dis-jointed when agencies worked together with key pieces of historical information missing or not being known by all those agencies who needed to know.

This Review was reminded of the importance of Sidebotham et al research¹¹ in helping professionals across the partnership piece together information regarding previous concerns of IFCSA either raised by children and/or parental issues including domestic abuse, parents’ own adverse childhood experiences, extended family networks and parental relationship history along with acrimonious separation.

This Review does not address the question directly of whether the IFCSA could have been prevented although it does consider how the IFCSA was or was not understood. This Review considers how agencies individually or when working together might respond differently or

⁸ Sexual abuse involves forces or enticing a child to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration or non-penetrative acts – see Working Together 2018, HMO DfE Gov: UK

⁹ Protecting Children from Harm: a critical assessment of child sexual abuse in the family network, Children’s Commissioner for England, November 2015

¹⁰ See Centre of Expertise for child sexual abuse research articles

¹¹ Triennial Analysis of SCR’s 2011-2014 Pathways to harm, pathways to protection, Sidebotham et al HMO DfE May 2016

try different approaches to reduce the risk of this happening to other children in the future. Specifically, to the children's experiences analysed it finds that during the period under Review:

- School was a "*safe haven*", with key relationships built and sustained
- Too much weight was given to children being able to keep themselves safe. This was influenced by the children's ages. This resulted in poor decision-making about likely or actual significant harm and risk levels.
- Having changes in workers, and not feeling heard or believed had a long-lasting impact on children feeling able to trust or build future relationships
- Professional curiosity did not result in positive and safe changes, with limited difficult conversations seen when there was a difference of opinion
- Historical information was not considered as it should have been
- Too much emphasis was placed on retraction within the children's account, and this effected the pace of decision-making
- Key information about risk was not shared with the network or the family at key times and this impacted on likely/actual harm being known.
- Moves between geographical area was significant
- Working together between Children's Social Care and the Police was dis-jointed and at times slow
- The culture in an organisation had a clear detrimental impact on professional practice
- Legal Safeguarding Orders were not progressed by Children's Social Care and Police, and this was a significant missed opportunity

Working with children where there are concerns of IFCSA is complicated. As seen in this LCSPR there may be times where there is no evidence to support professionals' hypotheses or a "*gut instinct*" that sexual abuse is occurring; there may be behaviours alerting professionals that all is not well in a child's world and a child may or may not tell someone about the abuse or may retract the information once shared. As this Review highlights, multi-agency professionals need to grapple with all these practice dilemmas regarding how best to support and protect children when concerns about IFCSA remain and when working in child safeguarding and legal systems which are primarily designed to work upon an evidential basis. Holding regular, protected time for discussion and reflection to consider such complex matters is crucial to professionals.

In reaching a summary with recommendations for practice and system change, the Review worked with a range of professionals to understand individual children's experiences and accounts. The input and levels of honesty shared from practitioners and managers has been invaluable in analysing just how complex intra-familial child sexual abuse is and how it can fall below the radar in a system designed to protect children from this type of harm. Great care has been taken to preserve the anonymity of those who were subjected to the prolonged and extremely traumatic levels of child sexual abuse within their families. Our heartfelt thanks go to the children and parent in sharing their experiences and in doing so helping the local safeguarding system make recommendations to develop in a way that holds families views as

integral to its support and services. The parent who is said to have caused the harm was invited to contribute to this review but chose not to participate.

The purpose and hope of this Review in working with the family and with multi agency professionals in P-DSCP is to build upon what works well, strengthen practice and systems where required and in doing so to keep further children as safe as possible from IFCSA.

3. Children & Family Perspectives: The Importance of Support & Services

Some family members have chosen to participate in this Review process and although this has not been an easy decision given the nature of the IFCSA, their insights have proven invaluable and extremely powerful to understanding how systems can best respond to this type of harm to children by adult family members who sexually abuse. Research¹² shows IFCSA can have devastating long-term impacts over a child's life course including poorer physical and mental health and relationship issues. However, this is not always all children's' experiences and much depends on individual coping mechanisms and the support they receive from professionals and non-offending family members.

The family have been able to highlight what support and services helped them and what was less helpful to them. The importance of building and sustaining relationship with key professionals in school is highlighted by the family as excellent practice in terms of listening, supporting both the children and non-offending parent, advocating and being honest about what they could and could not do.

- Listen to children carefully and offer a non-judgemental approach, especially when retraction is made. *"The words you use with us are powerful and stick in our minds. We also try to tell you through some of the things we do"*.
- Children are unlikely to keep wanting to re-tell their account or build new relationships if workers keep changing. It is too difficult to do this, even if you try *"really hard"*.
- *"Some decisions we make need to be seen through our eyes as children. Check out with us directly as sometimes the decisions we make are because of other dilemmas in our lives, such as wanting to stay at the same school where we have friends and feel safe over where we live"*.
- *"Explain what choices and options there are in a way that we can understand, as the language is confusing, and then check again that we understand this"*.
- Social Workers should take care not to be "sucked in" by adults who are highly manipulative and maybe consider visiting our home in two's so that observations can be made of the family dynamics and interactions. Consider the allocation of social workers in some family situations where misogyny and male power is highly dominant and controlling of situations
- Work with the other parent by listening to their views more and offer support to them. Share the actual reports and information at the time you receive them
- Ask the child and other parent how meetings should be run and how participation feels safest for them or there is a risk it is more damaging, albeit non-intentionally

In listening to the family, it is a salutary reminder that children who are held as having some degree of responsibility for keeping themselves safe or not feeling they are believed may

¹² See Centre of Expertise on CSA (<https://www.csacentre.org.uk/>)

experience increased negative outcomes, such as amplified self-blame. Similarly, blaming non-offending parents can impede their ability to support their child following telling of the harm they are experiencing. Understanding the factors that influence how people perceive the child, caregiver, and adult causing the harm is imperative for the protection and treatment of families who have experienced sexual abuse.

Much research by the Centre of Expertise for CSA¹³ shows that non-offending parents and adults in families play a critical role. The family share how it is vitally important to have support and services that put listening to each child and other adult in the family at the heart of its work, where professionals show children and non-offending parents respect, and that they believe them. Where professionals show through their actions that they care, have compassion, enable choice where possible, do what they say they are going to do, can remain optimistic and encourage them and explain the complex systems in which child safeguarding operates. The family cite many examples where this was achieved by education colleagues; where it was attempted by some in Child and Adolescent Mental Health Services and where it would appear to benefit from further thought by those on occasion by the Police and often by Children's Social Care at that time.

4.Key Practice & System Learning

This section considers three significant thematic areas when working with IFCSA. It draws upon the analytical, evidence-based work undertaken by the Review Group and Multi-Agency Learning Events with a group of practitioners and managers and highlights strengths in practice and systems where seen, and areas for further development and action.

4.1 Barriers and Enablers for children

This sub-section looks at how effective support and trusting relationships with professionals are critical for children if they are ever to feel able to begin to tell of IFCSA. This Review highlights how the mode of communication when telling of IFCSA can be varied in approach and writing and drawings to indicate harm can often feel safer for some children as opposed to saying things out loud. This CSPR is reminded of the key learning from Chris' CSPR¹⁴ which places importance of systems ensuring children having alternative ways of telling and giving evidence, such as providing written information and statements. Alongside the varied ways in which children might tell, this Review also highlights how it can be over a period of considerable time with retraction being common within this process. This review acknowledges the time and effort individual practitioners took to build a rapport, offer continued support and especially when retraction was heard but not always understood in a historical context.

The LCSPR notes the impact on relationships of COVID-19 and the families and professionals self-isolating and not being in education provisions as often, with more indirect modes of communication taking place. The Review also considered the effects on professional practice when working in rural locations when considerable travel and distance impacts on planning sufficient time for sessions with children within the working week. The Review also notes

¹³ See Research undertaken by Centre for Expertise on CSA (<https://www.csacentre.org.uk/>)

¹⁴ Cambridge CSPR Chris 2021 ([Cambridge CSPR Chris 2021](#))

how relationships can sometimes be more difficult to build or sustain when children move between geographical areas.

4.1.1 Children's decision-making to tell

Much research¹⁵ tells that a child's decision to talk to about sexual abuse is best understood as a process which is influenced by relationships and interactions with others: children need help to communicate, and professionals are as integral to the process as the child themselves.

The Impact of Retraction on professional decision-making

Retractions can be best understood as repudiating earlier information of having been sexually abused. Retraction can be a typical response for a child following telling someone and this may be due to having hesitated for not telling for so long, the child now finds out all the things they feared are true, such as the parent who is causing the harm denying the abuse.

Early research¹⁶ identified a pattern of behaviours known as the child abuse accommodation syndrome. This argues that while children who have experienced sexual abuse may tell others about it gradually or incrementally, many children remain silent about it, deny that it happened, or produce a series of telling of abuse followed by recantations. Learning from previous Serious Case Reviews¹⁷ recommend to practitioners working with IFCSA to “*act with caution*” when a child retracts information.

Retraction when telling your account of sexual abuse was a significant theme within this LCSPR. Weight was given to the child's words when they first said all was not well in their world, and this directly correlated to what actions were then taken in response to this. Similarly, if a child then withdraws this information, professionals can halt, or slow down child protection enquiries and actions. In this review it was found that issues with Police capacity resulted in a decelerated pace, which impacted on them being able to inform Children's Social Care on the levels of risk to the children.

Professionals often think about a child's communication as being a one-way process in which it is the child's responsibility to tell someone what is going on, and if they don't do this or do it and then retract the information, then there's nothing else that can be done. The impact upon professional decision-making is reflected upon by education professionals as they clearly believed the child had been sexually harmed and this sat alongside a complexity in practice of feeling at a loss as to what to do now, as possibly the child's retraction was not seen as part of the process of telling their account over time.

4.1.2 Participation is Protection – how we build relationships, listen to children & work to enable choice

¹⁵ Making Noise; Children's Voices for positive change after sexual abuse, Children's Commissioner April 2017 University of Bedfordshire, UK

¹⁶ Summit, R (1983) The child abuse accommodation syndrome. Child Abuse & neglect 7:177-193

¹⁷ NSPCC Repository C8234 Family D 2020 ([Overview Report CSPP Family D - 2020](#))

Much has and continues to be written about the power and influence of relationship-based practice with some consideration of the types of relationships involved.¹⁸ This Review shows how the benefits of a “*holding relationship*” as described by Ferguson’s work by certain education professionals was key in enabling the children to begin to tell what was happening in their family, to ensure their voice was heard and acted upon. The relationship built by the professionals was reliable, consistent in immersing themselves and working with the family, seeing them most days and becoming emotionally close to them, and understanding the power dynamics at play. These relationships at school were a protective factor in the children’s lives and were identified as such by the children and non-offending parent.

Conversely when this is not in place and most often due to system or cultural issues as opposed to professional choice, there can be considerable impact for the child. Having a stable workforce, where there are relatively few changes in practitioners is vital if children are to feel that they can trust and open-up about the most traumatic and personal matters happening to them in their families. The evidence would suggest that numbers of children allocated within children’s social care were not overly high during the period under review, but what was significant was the change in workers at critical times both at a practitioner and manager level. The reason for these changes were linked to organisational restructures in Children’s Social Care and this was further compounded by practitioner “churn” in the system due likely to cultural issues set by the then senior leadership team. The cultural and system issues are considered in Section 3.3.

A similar situation was also evident within the Child and Adolescent Mental Health Service (CAMHS). The competing pressures and demands including a lack of practitioner consistency, with part-time work arrangements, with long distances between offices, presented a barrier to relationships being built and accounts having a chance of being told, despite a diligent and persistent approach being seen by the final CAMHS practitioner.

4.1.3 The critical role of School in Keeping Children safe

Teachers are the professionals to whom children will mostly commonly tell¹⁹ and the way in which any professional engages with a child about whom concerns exist may either help or hinder.

This LCSPR shows consistent *good practice* in the vital role that schools play in protecting children from sexual abuse in families. The family share how “*the school could not have done anything more – they were amazing*” and this Review concurs with this view. There were educational staff who showed persistence, a caring and supportive child and family approach and professional curiosity. They clearly went above and beyond the typical role of educational professionals in sitting alongside the child to understand the child’s world when they were at home. School staff consistently took time to listen to the children, worked closely with parents and remained vigilant about behavioural indicators and changes. The review highlights the importance of protected safeguarding time for staff, maintaining accurate safeguarding records over time and the transfer of information between schools.

¹⁸ Ferguson, H et al 2020 Relationship-based Practice and the creation of therapeutic change in long-term work, Social Work Education, 1-19, 2020

¹⁹ Centre for Expertise CSA: Key Messages from Research on identifying and responding to disclosures of CSA September 2019 NSPCC

The mandatory safeguarding duties for schools in keeping children safe were embedded throughout the school²⁰. This part of the safeguarding system worked well in ensuring that staff were trained effectively to identify signs of abuse including what to do if they or someone else is worried about a child and responded accordingly. The designated teacher who was responsible for dealing with child protection liaised closely with internal educational professionals and the wider network. The multi-agency chronology undertaken for this Review is a practice and system reminder of valuing and enabling the role that key educational professionals play in building relationships with children, where they are often seen daily and trust is built so that when a child feels able to, they might begin to tell some of their account

4.1.4 Working with Adults who are suspected or known to be of harm to children

A key reflection shared related to how adults who sexually abuse children can also skilfully and subtly manipulate the professional network and the family. Grooming of children is a term described by the NSPCC as *“when someone builds a relationship, trust and emotional connection with a child so they can manipulate, exploit and abuse them”*²¹. The various multi-agency professionals involved in this Review all commented on how they perceived varying degrees of manipulation and controlling behaviours from the parent who abused when working with them, individuals did not have the opportunities in a multi-agency arena to verbalise these concerns and therefore these were not able to be adequately acknowledged and acted upon.

As Garboden²² reminds us, adults who sexually harm children often use the same techniques on professionals as with the children they sexually harm. There were examples given where the parent who was described by multiple professionals as *“very convincing”*. The adult would try to run rings around the professional network by professing, they were an innocent party and presented as polite, considerate, and charming, therefore potentially making it difficult for others to imagine they could do something wrong. Other approaches and techniques could also be seen at meetings, such as Child Protection Conferences where the adult would block others by talking over them or making sure they were present in meetings to intimidate or control other family members.

This Review highlights the need for professionals to have a regular dedicated reflective space at the time of the work being undertaken. Although supervision records show monthly sessions were held in Children’s Social Care, the session tended to be procedural in nature and briefly recorded. It is important to consider the often-subtle techniques and modes of behaviour employed by adults who harm children and then place meaning of this in the context of the child’s situation and decide what weight this is to be given when assessing risk to the child. Increasing professional understanding of how adults who sexually harm children think and behave is an important part of this risk assessment and preventing future harm.

4.2 Professionals Identifying & Responding to Child Sexual Abuse

²⁰ KCSIE Reference 2021

²¹ NSPCC Website “What is Grooming”

²² Garboden, M 2011 How Social Workers can Spot abusers attempts to manipulate in Community Care online

“Professionals rely too heavily on children to verbally disclose abuse... parents, professionals and the public must understand and know how to respond to signs and symptoms of child sexual abuse”²³

This section now considers the role of those professionals who work with children across the police, children’s social care, education, and health services, and how they need to utilise a sufficient knowledge, skills, and confidence to identify possible indicators of child sexual abuse and respond effectively to them.

Understanding Patterns of Harm & Risk Assessments

Some children who experience sexual abuse may show no outward signs that they are being abused, some will show a few and some many. For example, for some children, educational engagement appears to function as a coping mechanism for helping them escape the abuse (Fisher, et al 2017). Undertaking risk assessments is a key practice tool for professionals to understand and identify patterns of sexual harm and the risks posed by adults who may or have caused harm to children. As previously highlighted such work should involve considering the historical factors alongside the current factors that are causally associated with these risks, and the interventions that should be taken to manage or reduce the risk.

Sexual abuse risk assessment is a formidably complex task and at times is commissioned to specialist independent services in the UK, essentially to provide an independent view from the process of gathering information about individual adult family members to make decisions regarding their likely/actual risk of perpetrating sexual harm to children.

There were two risk assessments completed during the period under review, one commissioned by Children’s Social Care (CSC) and one undertaken by CSC to consider wider family members and whether they could provide safety to the children. The independent report was not shared with multi-agency professionals and the family prior to the Child Protection Conference. The reason for this was based upon a general practice in Children’s Social Care to not share external reports with multi-agency professionals. This Review finds the independent report to be contradictory in nature, with a confusing conclusion of the adult who caused likely sexual harm as being assessed as a continued sexual risk to children and with a plan outlined for the children to return home to his care. The limited protective adult network was highlighted in the Report along with a future plan outlined which placed far too much onus on the individual children to take responsibility for their own personal safety, by putting locks on their own bedroom doors and completing keep safe work.

With the benefit of hindsight, it is surprising that the final independent Report was not challenged by Managers in Children’s Social Care due to the incompatible nature of the risk identified and the safety plan outlined. However, quite the contrary was seen with this Report setting the scene and leading the way for future action planning by Children’s Social Care. If agencies commission specialist reports care must be taken to look at them objectively and practitioners should be empowered to be able to challenge the content.

The 2nd assessment of risk undertaken by Children’s Social Care to consider where the children should live within their family network failed to recognise the extent of sexual offending seen

²³ Multi-agency Response to CSA in the family environment: Joint Targeted Area Inspection 4/2/20 Gov.UK

in the family over considerable time by several children. There was an over reliance by Children's Social Care on the adult male's interpretation of events versus what the children were trying to say and show in their behaviours and the age of the children was given considerable weight when considering what other safeguarding measures the local authority could put in place. The delay and slow pace of the Police investigations further compounded this silo-ed view and did not provide a full picture of likely sexual harm.

4.2.1 Thresholds of Significant Harm & Child Protection Conferences

A Child Protection Plan is made when a child is judged to be at risk of likely or actual significant harm, where the level of harm affects the health, welfare, and development of a child²⁴. The multi-agency Plan should say what the specific risks are to the individual child and the actions that will be needed to keep the child safe. The Plan is made at a meeting called a Child Protection Conference attended by the family and a range of multi-agency professionals. At any one time there are approximately 43,000 children in England²⁵ with Child Protection Plans. Of these, fewer than 5% have a plan under the category of child sexual abuse which equates to approximately 2,000 children.

This Review has analysed the Strategy Discussion and one period of Child Protection Planning that followed and makes the following thematic conclusions to aid future practice and system thinking when at a threshold of likely/actual significant harm:

- As part of the pre-Conference preparation the Child Protection Conference Team should ensure the relevant multi-agency professionals/services are invited and represented at Conference. This should link to the risk identified to ensure the right people are around the table
- Pre- Conference Planning between the individual family members, Social Worker and Chair should take place to agree how best to ensure all voices are heard in a safe way and family dynamics are fully considered. Consideration of the risk of re-traumatising children may lead to a decision to hold a conference in two parts.
- Written risk assessment documents should be shared with family and multi-agency professionals before Conferences to inform child protection threshold decision-making and planning
- Minutes should provide clear explanation of the views of multi-agency partners on thresholds for legal proceedings
- When deciding when to "step down" from a child protection plan, evidence must be clear on the impact on risk of any completed actions. Care must be taken to ensure work is effective and not just ticked off as being undertaken
- Valuing professional difference of opinion and the right to dissent if agreement cannot be reached should be made explicit at the beginning of all Conferences

²⁴ WT 2018 Reference

²⁵ Reference for CP Conferences

4.2.2 Safety Planning

This Review finds the multi-agency safety planning was heavily reliant on an external risk assessment which in hindsight should have been challenged as it was contradictory in nature. This set the tone for an unrealistic and over optimistic plan of action which placed far too much emphasis on the children keeping themselves safe.

This Review finds that in shifting the focus from the adult who has caused the harm to encouraging the child, who is or is likely to be harmed, to keep themselves safe has consequence for future risk. There is an approach of adopting the popular practice approach undertaken in many local authorities' children social care teams of undertaking child focused keep safe work. Although important work at times, such a single approach and onus on the child taking responsibility diverts from the primary risk not being adequately addressed with the adult causing or likely causing the harm.

The age of the children considered in this Review, along with professionals holding the view that they presented as articulate and knowing their own minds, diverted the focus from the safeguarding responsibility of the partner agencies in ensuring the children were safe from significant harm from the adult who was abusing them. Balancing these competing demands with older children is difficult and needs authoritative practice from a range of professionals to ensure the child's welfare and safety always remains the paramount consideration. The manipulative and controlling behaviours of the adult in the family causing harm then resulted in a diversion from professionals checking that appropriate and thorough work was being undertaken with them to address their harmful behaviours. This approach resulted in an ineffective safety plan with sexual risk remaining at a very high level in the family.

The School Nurse team offered minimal emotional support in school and provided information about the digital mental health chat service available. No specific referral or role was requested of the School Nursing team at the initial child protection conference which they had attended. The Protection Plans also did not consider asking for expert input from key professionals from the Sexual Health Services and they were not invited to the Conferences. This was a practice oversight as their work might have focused upon understanding risk behaviours and the importance of when children retract information concerning sexual harm and what meaning is given to this.

The Review considered the pilot project of two specific posts, commissioned for a period of time for Child Protection Specialist Nurses, to attend all Review CP Conferences for school age children. This is where no other health was involved except the GP to represent health views, and in addition to provide reports for those they are involved with. This specific funded role, which has since ceased, was seen to have contributed to Health representation.

4.2.3 Police Actions & Legal Safeguarding Orders

The knowledge gap and time lag between Children Social Care & Police actions were significant, with a disconnect seen and silo working evident. The Police capacity to examine the adult's devices impacted significantly on the speed of the full picture being known by children's social care and risk levels and plans being adjusted accordingly. At this time, the

Police view was that any criminal court case was likely to be flawed because of retraction. This is likely due to criminal prosecutions requiring a different burden of proof and the Crown Prosecution Service are concerned about the issue of challenge to vulnerable witnesses. This differs to a Family Court approach and the advice given by Dorset Council Legal Services at this time.

The combination of all these factors had an impact on the children involved and was likely to have resulted in them being placed at risk of further sexual harm from the family member, as key information was not progressed and then shared with partner agencies

As previously considered, in some situations of IFCSA the child retracts what they have previously shared. This is seen by police, children's social care and legal professionals as posing problems for both civil and criminal proceedings. It is seen in some research²⁶ that the collection and examination of retraction statements often does not receive the same careful attention as in the case with investigations of original allegations made and this Review finds clear evidence for this. Where retractions are examined and evaluated with care, they can add to the confidence of the conclusion rather than simply throwing doubt on that.

Legal thresholds were considered by Children's Social Care on two occasions, following legal advice that threshold was met, however the decision-making process regarding potential initiation of proceedings should have been considered at an earlier opportunity and then was too slow. The rationale for this likely delay were due to organisational cultures at the time in Children's Social Care and a different direction and management oversight being given at a Team and Senior level in Children's Social Care, despite clear direction being provided by Legal Services that threshold was met for proceedings on both occasions.

The law is clear at the age of 17 years the local authority can no longer apply for a care order (Section 31 (3) Children Act 1989); however, the children were not yet at this age. The children's adolescent ages were however seen as significant being towards the older age of childhood, and this meant ineffective decision-making about pursuing legal options, whether this was voluntary accommodation or interim care orders or via other legal safeguarding orders available. A predominant view was held that as the children were clear in their views, this should be given due weight and given safety work had been completed, it was deemed little else could be undertaken at this point – in effect professionals felt their *"hands were tied"* as the view to pursue a legal route was not supported at a Senior Level in Children's Social Care.

Although it is acknowledged the system and options available are somewhat more limited for older children, this review suggests that there were other routes available and given that a full picture of risk was not known, with the benefit of hindsight this was an incorrect conclusion to draw. However, this also needs to be understood within an organisational and partnership context at that time where professionals felt it was difficult to challenge more senior decisions about other available options. It is clear from discussions with professionals, this was a significant complex dilemma and with emotional impact on practitioners when considering what to do to best help the children in this situation.

²⁶ The Evaluation of Retractions in Sexual Abuse Cases, 3/4/2002 Bryan Tully, Wiley Online Library

There is work underway in Pan-Dorset to strengthen practitioner and manager knowledge across the partnership about the various legal orders available when there is a likely/actual risk of sexual harm at all ages of childhood, from 0 – to 18 years old.

Under Section 113 Anti-Social Behaviour, Crime and Policing Act 2014, Sexual Risk Orders (SRO) could have been considered by a court where a person has carried out an act deemed to be of a sexual nature and who, as a result, is believed to pose a risk of harm to children. “Acts of a sexual nature” are not defined in legislation so can be dependent upon the individual case circumstances, context, and apparent motive. The Orders prohibit the defendant from doing anything described in the Order and can include a prohibition on foreign travel and Internet use. An SRO can be granted for a minimum of 2 years and has no maximum duration. The Order may specify different time periods for different prohibitions. Interim SROs can be granted while a suspect is on bail and even if the criminal case fails on evidence the SRO application could continue. SRO’s make the individual subject to full notification requirements for registered sex offenders for the duration of the Order. Other benefits are that an offender does not need to be in Court for the Order to be granted. Breach of a Sexual Risk Order is a criminal offence which has a power of arrest and is punishable by a maximum of five years’ imprisonment.

As detailed in Section 113 Anti-Social Behaviour, Crime and Policing Act 2014, also details Sexual Harm Prevention Orders (SHPO). These could be applied for where an individual already has a schedule 3 or 5 offence under the Sexual Offences Act 2003, which incorporates a wide variety of offences, and it can be argued that someone is likely to cause further sexual harm. The Orders prohibit the defendant from doing anything described in the Order and can include a prohibition on foreign travel and Internet use. An SHPO makes the individual subject to full notification requirements for registered sex offenders for the duration of the Order. Breach of a Sexual Harm Prevention Order is a criminal offence which has a power of arrest and is punishable by a maximum of five years’ imprisonment.

Both orders can be applied for by a Chief Officer of the Police or the Director General of the National Crime Agency and would be dependent on the necessary criteria being fulfilled.

4.3 Multi-agency systems designed to keep children safe

4.3.1 The Complexity of IFCSA & Organisational Safeguarding Cultures

Through discussions with practitioners as part of this LCSPR it is evident that at times those working with children who may be at risk of sexual abuse can find it a difficult area to think and talk about. This is of course understandable as it is complex work, can evoke emotional responses and professionals can worry about getting a gut feeling or hypothesis “*wrong*”. All of this can be further bound up in a professional worry of jeopardising police investigations if they then “*say the wrong thing*” to a child.

Every day, professionals from health, education, the police, and children’s social care make decisions about the safety and wellbeing of many children and their families across the UK. Such decisions when relating to IFCSA are made in situations of uncertainty, with time and resource pressures. A consistent theme heard during the Review related to professionals

having enough space and ring-fenced time to read, critically think and reflect on the complexity of IFCSA either within a single agency space or in multi-agency discussions. Professionals talked of the impact of the range of workload pressures, which at times, and with an openness and honesty shared, impacted upon their ability to make decisions.

Social Workers and Managers as the lead professionals often must make several highly complex and challenging decisions each day when working within statutory frontline assessment teams. Research undertaken on behalf of the Department of Education²⁷ suggested there were four key behavioural factors that can complicate or reduce the efficacy of social worker's ability to make such decisions. These are time and workload pressures; behavioural biases that can affect judgements; the number of complex decisions made within a day which can lead to "decision fatigue" and lastly social workers often having low quality information shared with them and so need to spend time piecing things together and less time is available therefore for analysis. All four factors are evident within the period under Review.

This Review concurs with Ferguson's²⁸ analysis of how a complex interplay of factors can impact on practitioner and managers decision-making in Children's Social Care as in this situation it is likely that workers were overcome and immobilised by the emotional intensity and complexity of this situation whilst also being affected by the organisational culture during a re-structuring process and Senior Manager tone set during the period under Review. The subsequent permanently recruited Senior Management Team in Children's Social Care recognised this unsatisfactory workforce situation with speed and the previous unsatisfactory and regrettable situation has been discussed openly as part of this Review process.

The culture has since changed significantly due to organisational changes in the senior management team in Children's Social Care, but it may have made individuals feel at the time anxious of their own professional futures given the re-structuring and unsupported in their decision-making, making containment of their feelings and the ability to think clearly likely to be impossible even when supervision and management oversight was regular.

The, at times, unbearable level of complexity and anxiety for individual workers and managers when working with IFCSA is not highlighted enough in child safeguarding work undertaken by statutory agencies. It should be considered in the context of ensuring organisational safeguarding cultures which place the importance on creating workplace conditions which ensure practice flourishes in conditions of support and critical thinking when working with families. The Senior Leaders involved in this Review process have given assurances and examples of how this work is developing in Pan-Dorset in Children's Social Care.

4.3.2 Sharing Information

As part of the Review process during learning events held with multi-agency professionals' knowledge gaps in the chronology of key information held by individual agencies became evident. This is likely due to information being seen and held by agencies as single occurrences as opposed to building up a picture of cumulative harms over time. The use of single and multi-agency chronologies to understand the children's accounts was weak. If

²⁷ Clinical Judgement and Decision-Making in Children's Social Work, 15/4/2014, The Behavioural Insights Team, DoE

²⁸ Ferguson, H 2016 How Children Become Invisible in Child Protection Work BASW

information isn't shared effectively between agencies, practitioners view events in isolation, which may delay the identification and assessment of risks and therefore the instigation of appropriate child protection actions. For example, child protection information was not transferred between systems when children moved GP catchment areas, and this was significant to health professionals at the time not knowing the full extent of concerns and risks. Inefficient or ineffective multi-agency working can result in missed opportunities to safeguard children, particularly when multi-agency processes such as multi-agency chronologies are not well embedded in local systems.

Despite these knowledge gaps, this review also finds good examples of day-to-day information being shared on a regular basis via email or telephone exchange between education, health, and children's social care professionals. This shows that multi-agency professional relationships were established and maintained in the partnership in Pan-Dorset and this needs to be built upon to ensure information collation and risk assessment processes are now aligned with this relational practice to ensure full pictures are known regarding children.

4.3.3 Professional Curiosity & Having Difficult Conversations

Most professionals involved in this Review held firm views that despite retraction, the children were at risk of sexual harm in their family. There were not rose-tinted glasses, or an over optimistic approach adopted by key professionals but rather a paralysis and uncertainty about how to manage the risk and this resulted in ineffective actions and decision-making.

There was a good level of professional curiosity held at times by professionals, though a need for a fuller understanding of the dynamics of IFCSA to develop skill and knowledge in the range of strategies to respond to situations when there is uncertainty was needed. If this were embedded in future practice this would result in actions and plans being used more effectively to keep children safe as critical thinking would be backed up with a sound knowledge base around working effectively with adults who sexually harm children. The role of a reflective supervision space is central to developing such attuned skills in practice.

There were differences of professional opinion held concerning key matters such as stepping down from a Child Protection Plan and the decision to not pursue a legal route to safeguard the children. These differences were not aired as they should have been and procedures such as the Escalation Policy²⁹ which is designed to support professionals with professional difference of opinion were not utilised. The reasons for this are linked to the afore mentioned leadership culture in Children's Social Care which appeared to permeate throughout the partnership with partner agencies knowing that raising a different opinion was unlikely to yield a positive change in outcome or direction for a child at this time. Work is on-going and led by Children's Social Care to review the Escalation Policy and to ensure a culture of having more difficult conversation as part of everyday practice.

4.3.4 COVID19

Towards the end of the period under Review professionals were faced with the unprecedented complexities of practising when in a global pandemic. This impacted on the

²⁹ Pan-Dorset Safeguarding Children's Partnership Escalation Policy ([PDSCP Escalation Policy](#))

ability of education professionals and Children's Social Care to understand the children's day to day experiences as face-to-face social work visits were limited and school did not see the children daily as before, although they did ensure regular phone contact with the family. Risk clearly increased during this period, despite the best efforts of practitioners.

5. Conclusion and Recommendations

The aim of this LCSPR, and the overriding hope of the family involved, is to help and support professionals, agencies and multi-agency partnerships across the country who may be working with children where there is actual or likely significant harm from IFCSA. This LCSPR has shown the complexity of working with those adults who sexually harm individual children in their families, and skilfully manipulate their family systems and those professionals working with them. The following recommendations are made with this at the forefront of the Pan-Dorset Partnership.

There are five local recommendations.

Local Recommendations:

Recommendation 1: A Multi-Agency Sexual Abuse toolkit is available to all the Partnership via the Pan-Dorset Safeguarding Children's Partnership website

Action Needed: The Partnership's Business Manager will lead a multi-agency task and finish group so as to facilitate Partnership support with the development of the Children's Social Care toolkit being a multi-agency toolkit within a maximum of 9 months of this Review being published. The task and finish group must include focus on the learning from this Review and consider strategies for when children retract.

Recommendation 2: Practice in relation to IFCSA needs to be strengthened in Children's Social Care.

Action Needed: To achieve this Joint social work visiting is considered by the Senior Leadership Team when allocating children where IFCSA is the main risk. In addition, the CSC Supervision Policy and template will be reviewed by the Head of Quality Assurance and Partnerships to allow dedicated time to reflect on the complexity of IFCSA.

Recommendation 3: Child Protection Case Conference Protocols and Practice need reviewing

Action Needed: Head of Quality Assurance & Partnerships in Children's Social Care to lead on work with the Child Protection Conference Team to review the existing practice protocols for child protection conferences that include what and how independent information is shared along with a revised participation policy of children which ensures their voice is heard free from influence. These updates to policy and procedure will be available in Tri-X within 9 months of publication of this Review.

Recommendation 4: Children's Social Care, Police and Legal Services Joint protocol is required

Action Needed: The Business Manager for Pan-Dorset Partnership to set up a Task & Finish Group with Children's Social Care, Police and Legal Services to jointly produce protocol when working situations in IFCSA. This should consider:

- the ages of children
- the timing of investigations
- the range of legal orders available to pursue
- future safety planning.

The Protocol will be communicated with partners and will be published on the Pan-Dorset Safeguarding Children's Partnership website within 9 months of this Review.

Recommendation 5: Health and Public Health to assure the Pan-Dorset Partnership that all health information is available at Child Protection Review Conferences and to have the appropriate Health professional present to be part of multi-agency decision making for school age children

Action Needed: Within 6 months of this Review, the Pan-Dorset Safeguarding Children's Partnership Senior Leadership team for Dorset must decide an action plan to address Health attendance at Review Child Protection Conferences where no named health professional is already involved with school age children. This could be representation from any child health representative as health consider appropriate.

Our final thoughts and gratitude must sit with the children involved in this thematic summary. They have shared their very painful and traumatic accounts to help professionals who work with families and to support those who design systems to consider what matters most to families to ensure children are kept safe from harm when this type of abuse is suspected or known. Our hope for them is that they are supported and helped to find a way to recover from these experiences as they journey through their lives.

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