Northamptonshire Safeguarding Children Partnership

Local Child Safeguarding Practice Review

"Child Bk[1]"

Report Author

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[1] An anonymised name.

1. Introduction

Why this Local Child Safeguarding Practice Review (LCSPR[2]) was Initiated.

1.1 This LCSPR (to be referred to as the review throughout this document) was initiated because of concerns about the response from Northamptonshire safeguarding partners to information about an adult, Mr D, who came under investigation for downloading and distributing child sexual abuse images of children[3]. There was a narrow focus on the risk Mr D posed to his own young children, and a lack of consideration of any children in his wider family, including a stepsibling and Child Bk, the child of his parent's partner. Mr D was later found to have been sexually abusing Child Bk (aged 11) over a period of 12 months. Mr D was convicted of rape and is now serving a lengthy prison sentence. There also emerged concerns that Child Bk's mother dismissed concerns that Mr D posed a risk to Child Bk and failed to keep her safe. Child Bk is now in Local Authority Care. The impact of the child sexual abuse Child Bk experienced has been profound for her, and she is now receiving appropriate help and support.

Process of the Review

1.2 The concerns about Child Bk were subject to a significant incident notification[4] and rapid review process[5]. This led to the identification of early learning for each involved agency and an action plan was developed to take forward the single agency improvements required. It was agreed that an independently led Local Safeguarding Practice Review would be undertaken.

1.3 An independent lead reviewer was commissioned[6]. A panel of senior representatives from the agencies who had contact with Child Bk was convened and a local Chair[7] of the review panel was identified to support the process. This panel helped set the terms of reference for individual agency reports, building on the existing rapid review process. The panel were the critical friend to the independent reviewer, providing local knowledge, helping with analysis and the framing of this report including appropriate recommendations. The independent reviewer would like to thank them for their reflections and openness to thinking about local and national practice regarding child sexual abuse.

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[2] Local Child Safeguarding Practice Reviews (LCSPRs) are locally conducted multi-agency reviews of serious child safeguarding cases. They are required by law when a child has died or been seriously harmed and there is suspected abuse or neglect[4].

[3] Indecent and Prohibited Images of Children | The Crown Prosecution Service (cps.gov.uk)

[4] Under the Children Act 2004, if a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England. Child Safeguarding Practice Review Panel guidance for safeguarding partners (publishing.service.gov.uk)

[5] A **rapid review** in the context of safeguarding is a process that aims to provide a quick and comprehensive understanding of a serious safeguarding incident. It is a **time-limited** review that is conducted by safeguarding partners to identify the facts of the incident, immediate actions taken, and learning for the partnership and practitioners. Child Safeguarding Practice Review Panel guidance for safeguarding partners (publishing.service.gov.uk)

[6] Jane Wiffin is a social worker by professional background. She has extensive experience of carrying out and publishing LCSPR's.

[7] Helen Adams is Local Learning Review subgroup chair and Head of Safeguarding Northamptonshire ICB.

1.4 This report was written by the independent reviewer, and it has been discussed and approved through the appropriate local governance processes across the Northamptonshire child safeguarding partnership.

1.5 The data analysis for the review included the rapid review reports, the commissioning of single agency reports and some original case records such as assessments and police information were also viewed. Individual interviews were conducted with those who knew Child Bk, her family and Mr D. The reviewer would like to thank the frontline practitioners for their time, thoughtfulness, and reflections. Their views have been incorporated into the overall analysis.

Family Involvement

1.6 Careful thought has been given to how to include Child Bk in this review. This has been a difficult and traumatic time for her, and therefore it has not been appropriate to meet with her or her family.

Background Information:

1.7 Child Bk grew up with her mother, Person B, and an older sibling. The family are white British[8]. She was known to services from birth due to concerns about neglect as well as physical and emotional abuse. Her mother, Person B, misused alcohol and was subject to domestic abuse from several partners, which Child Bk and her sibling witnessed. The household was chaotic and there were inappropriate adults present. Child Bk's older sibling was sexually abused by one of these adults. Over the years there were several referrals to children's services, there were early help plans[9] in place for short periods of time and a period of child in need planning[10]. This closed without a reassessment of Bk's needs being completed and against the wishes of Child Bk's primary school who remained concerned about her emotional wellbeing. There was considerable evidence of cumulative harm, and little change in Child Bk or her sibling's circumstances.

1.8 Child Bk was well known and well liked by her Primary school. They provided her with support and were part of the many short term early help plans. Her secondary school describe her as shy, reserved, and lacking in confidence. They report that Child Bk had a small group of friends who were important to her and with whom she was more confident and boisterous. She loved art and animals. The school Child Bk attended recognised that she had social and emotional needs due to her parental and family circumstances and put support in place. In her first year of secondary school there was evidence of self-harm and ongoing evidence of the impact of trauma on her wellbeing.

[8] Some details are not included to ensure the privacy of Child Bk and other children in this family.
[9] Early help and early intervention are forms of support aimed at improving outcomes for children or preventing escalating need or risk. Because of this they are also sometimes referred to as prevention or preventative services.
[10] A child in need plan is services provided to address the needs identified for children under section 17 of the Children Act 1989. It will contain the support which is being provided to a child and/or family by Children's Services. The plan should set out: what is working well within the family; what support is required and why; which agencies will provide the required services; what the child and/or family agree to do.

1.10 Mr D is white/British. His parent was Person C and he had other siblings. He and the siblings were removed from their parent's care as young children due to significant concerns about physical abuse and neglect alongside parental alcohol misuse. One of his siblings was sexually abused by an adult who lived in the family home. His parent Person C started a new relationship with Child Bk's mother, Person B; the timeline for this is not known, because there was little exploration of either family's history when more latterly, they became known to services.

1.11 When Mr D was arrested, he was living with his partner and their young children. They had not had any involvement with specialist services and the school the eldest sibling attended were happy with his progress.

2. Chronology of Professional Involvement and background information

2.1 In April 2019 Northamptonshire Police received intelligence that the home address of Mr D was linked to the possession, distribution and viewing of animated child sexual abuse images (Often referred to as indecent images of children (IIOC). Contact was made with the multi-agency child safeguarding hub (MASH[11]) to seek information about children in the home. There was no discussion at this point about other children that Mr D might be connected to within his wider family and who else could be at risk of harm. Mr D was arrested and released on conditional bail not to have any unsupervised contact with children (under the age of 16) and to live with his parent, Person C. There was no exploration by the police of Person C's circumstances, relationships or links with children, which might then cause them to be at risk. They therefore did not identify Person B, or her daughter Child Bk. There was also a half sibling who was still a child and who was not identified. This issue is addressed in the analysis section.

2.2 The police made a referral to Northamptonshire Children's trust MASH (NCT-children's services) who concluded there was a need complete a child and family assessment[12]. Whilst this was ongoing the police decided that it was not proportional to extend Mr D's bail conditions, because NCT were involved, and he was released under investigation with no bail conditions in place. This decision would have ordinarily been made in conjunction with the wishes of any known victims. At this stage there were no identified victims[13].

2.3 The child and family assessment took place. This focussed on Mr D's immediate family, and there was no discussion of any links with children in his extended family. Mr D and Ms D signed written agreements that Mr D would live with his parent (Person C) and would have supervised contact with the children at the maternal grandmother's (MGM) home pending the outcome of the police investigation. The connection with Child Bk and her mother, Person B, was not made, and therefore no assessment of the risk Mr D might pose to Child Bk, despite his link to her partner. There was also no focus on Mr D's younger sibling (aged 15 at this time but living in another area). The need for mapping of all connections when there are concerns that about an adult showing a sexual interest in children and the importance of a strategy discussion[14] being held is discussed in the analysis section.

[11] The Multi Agency Safeguarding Hub (MASH) brings together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children.
The MASH setting allows professionals to efficiently and quickly gather and process information in order to assess risk.

[12] Child and family Assessments are undertaken by local authority children's services in partnership with multi-agency partners. They involve collecting and analysing information about children, young people and their families with the aim of understanding their situation and determining recommendations for any further professional intervention.

[13] Bail | The Crown Prosecution Service (cps.gov.uk)

[14] The purpose of a strategy discussion is to decide whether the threshold has been met for a single or joint agency (HSC and Police) child protection investigation, and to plan that investigation. They happen when it is believed a child has suffered, or is likely to suffer, serious harm.

2.4 There was a significant delay in Mr D's electronic devices being examined due to capacity issues and quantity of devices needing to be examined. At the beginning of December 2021, the Police informed children's services that they had received an interim forensic report and a number of child abuse images had been found on Mr D's devices. Mr D was interviewed and denied accessing or viewing them. The police investigation continued.

2.5 Children's services undertook a reassessment of Mr D's partner and children at this time. Once again this remained narrowly focussed on his immediate family.

2.6 Child Bk moved to secondary school in September 2021 (year 7) and the secondary school were made aware by the Junior school that Child Bk had social and emotional needs and a long history of children's services including concerns about neglect, exposure to domestic abuse and parental alcohol misuse.

2.7 In November 2021 Child Bk started to self-harm, with some superficial injuries and the school supported her to access counselling. In January 2022 Child Bk's school attendance dropped and this started to be monitored by the Education Welfare Officer (EWO)[15].

2.8 In February 2022 the school were concerned that Child Bk had some communication and friendship issues, and they involved Target Autism[16] who noted that Child Bk seemed quite anxious and as there were concerns about self-harm, they recommended a referral to CAMHS[17]. This did not happen due to a miscommunication within the school.

2.9 In April 2022 Child Bk went to the GP with her mother reporting that she was experiencing abdominal pain and headaches. These symptoms were reported to have been ongoing for the last year. Child Bk was seen with her mother, and she was asked about whether she was 'sexually active'. Mother answered for her and said 'no' for Child Bk. Child Bk was seen again by a GP in May 2022 with her mother with continued abdominal pain. This was to be monitored and exploratory tests undertaken. The GP practice were unaware of the concerns regarding Mr D and so did not consider possible differential diagnosis of child sexual abuse.

2.10 In June 2022 the school received an anonymous referral saying that Child Bk had been seen out in the community with a man, who was a relative and was a 'sex offender'. The designated safeguarding lead (DSL[18]) contacted, the MASH and the police.

[15] The Education Welfare Service (EWS) gives professional support to make sure that parents and carers fulfil their statutory obligation to send their child to school regularly and tracks pupils who go missing from school.
[16] A local service supporting children with any communication needs across the autism continuum and the professional working with them. TargetAutism.co.uk
[17] CAMHS stands for **Child and Adolescent Mental Health Services**. It is the name for the NHS services that assess and treat young people with emotional, behavioural or mental health difficulties.
[18] A designated safeguarding lead is a person appointed to ensure that a school safeguarding policy is followed by all members of staff in the setting. They act as the first point of contact for any safeguarding or child protection incident or concern in the setting. The role of the designated safeguarding lead is common in nurseries, schools, and other educational settings, as well as healthcare settings such as GP surgeries and hospitals

2.11 The police were aware that Mr D was under investigation for watching child sexual abuse images and they visited the school two days later to see Child Bk, who was not in school. The DSL shared concerns about Child Bk's vulnerabilities and provided information about the family, including the history neglect, children's services involvement, and Child Bk's mother's alcohol misuse.

2.12 The police officers went to the family home. Child Bk's mother said that the reason that Child Bk was not in school was that she had a urine infection, for which she had medication from the GP and she had also been for a blood test. The police asked Child Bk and her mother about Child Bk's connection to Mr D, and if they had concerns about his behaviour. The written record of this discussion uses the word 'inappropriate behaviour', and it is unclear how explicit it was made that they were asking about concerns about Mr D possibly sexually abusing Child Bk. This is picked up in the analysis section.

2.13 Child Bk was seen on her own; she said that Mr D was "like a brother to her"; he would sometimes meet her from school and at other times he would be at her home when she came back from school. They had regular contact. She said again she had no worries about him. It remains unclear how directive the questions were and how explicitly they were focussed on sexual abuse. This is addressed in the analysis section.

2.14 The police concluded there were no safeguarding concerns and submitted a public protection notice (PPN[19]) outlining their visit to MASH. The police also contacted the school to report their conclusions that they believed the anonymous referral was malicious, and that Child Bk and Mr D were like 'brother and sister' due to their parent's long-term relationship. The school were uncertain about this conclusion but thought that the Police had access to Mr D's offending history and had used this to inform their risk assessment. The school were aware of the escalation policy but did not consider using it because they did not doubt the actions of either children's services or the police. The school believed a full risk assessment would take place through Police and children's services involvement.

2.15 The children's MASH agreed that the referral from school would lead to a child and family assessment. This was picked up by the MASH health representative who shared with the GP and school nurse that a referral had been received and accepted for assessment; no further details were provided.

2.16 In July 2022 the crown prosecution service (CPS[20]) authorised a charge for Mr D of downloading possession of Indecent Images of Children (IIOC) and he pled guilty. He was at this point awaiting sentencing.

[19]A Public protection notice (PPN) is an information-sharing document that records safeguarding concerns about an adult or child. PPNs are shared with partner agencies to inform a multi-agency response.
[20] The Crown Prosecution Service (CPS) prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales. The CPS is independent, and we make our decisions independently of the police and government. About CPS | The Crown Prosecution Service

2.17 The child and family assessment took place in August 2022 and consisted of one home visit. The conclusion of the assessment was that there was no need for further action from children's services and that Child Bk could seek advice at school if she had any worries; what those worries might be were not defined. Children's services did not inform the school about the outcome of their referral, that an assessment had been completed or that they had recommended Child Bk seek support from them if she needed it. This falls significantly outside expected practice and is discussed further in the analysis section.

2.18 This assessment was inadequate in a number of areas:

- Multi-agency information was drawn entirely from the police PPN submitted to MASH and there was no direct contact made with any of the agencies that knew Child Bk.
- There was no risk analysis or safety planning considered.
- Concerns around possible sexual abuse were not named.
- There was limited analysis, and it did not take account of the known history of Child Bk and her family or of Person C and known concerns from the past.

2.19 There was no feedback provided to the school, so they were unaware that an assessment had been completed. Local Guidance makes clear the need for feedback to be given all referrers about decisions taken and suggestions for other sources of more suitable support[21]. Where this feedback is not provided professionals should always follow up their concerns. If they are not satisfied with the response, they should escalate their concerns by accessing the Northamptonshire Conflict Resolution Policy[22]. School did not follow up the referral or seek any further information. The school acknowledge they had a responsibility to follow up the referral and to use the partnership escalation process if they were unhappy with the outcome. This is reflected in their single agency action plan.

2.20 In September 2022 Mr D was sentenced to a 24-month Community Order[23] with 2 requirements, mental health treatment and rehabilitation activity. A sexual harm protection order (SHPO) was put in place and Mr D would therefore be placed on the sex offender register for 5 years and be subject to sex offender notifications.

2.21 Child Bk's school attendance started to deteriorate further in September 2022. There was a home visit by the EWO to discuss how to best support her. Child Bks mother reported a nasty bout of tonsillitis and ongoing feels of dizziness, nausea and stomach cramps. Child Bk was brought to the GP in October

[21] Referrals (proceduresonline.com)

[22] Northamptonshire Thresholds and Pathways document, clause 4.2 Case / Conflict Resolution Procedure (proceduresonline.com)

[23] A community order is a type of sentence that a court can impose on an offender instead of sending them to prison. It usually involves some form of unpaid work, treatment, or supervision in the community. The purpose of a community order is to punish the offender, help them rehabilitate, and prevent them from committing further crimes. Community sentences: Overview - GOV.UK (www.gov.uk)

2022 complaining of stomach pains, nausea and a vaginal infection. She was examined, thrush was diagnosed, and medication provided. She was brought again in November 2022 with similar symptoms. The GP was unaware of the referral to children's services and concerns about Mr D, but given Child Bk's presentation, the possibility of sexual abuse (either intrafamilial or extrafamilial) should have been considered, and action taken to establish whether this was a concern. This is picked up in the analysis section.

2.22 A probation officer was allocated at the beginning of October 2022. She contacted the police offender manager (OM) to see if he wished to attend the induction planned for the following week. There was no reply from the OM, who saw Mr D two days later. At this meeting Mr D confirmed he was aware of the Sexual Harm Protection Order[24] and the requirement of the sex offender register[25]. He was assessed as posing medium risk of harm to children.

2.23 The probation officer met with Mr D and asked him about any children that he was in contact with. He provided details of his own children and Child Bk. The probation officer found that he also had a stepsibling who was 16 and living in another county. The probation officer told Mr D that he was to have no contact with these children until she had completed checks with other agencies. Those checks were undertaken. The recent assessment process for Child Bk was shared and the agreement that Person B would supervise all contact. It was also agreed that Mr D's contact with his stepsibling should be supervised.

2.24 In January 2023 the OM contacted the probation officer to report concerns that Mr D was downloading further animated images; the inappropriateness of this was discussed with Mr D at the next probation meeting, and work was planned by the probation officer to address his offending behaviour.

2.25 In January 2023 Child Bk shared information that she was being sexually abused by Mr D; there quickly emerged concerns that her mother, Person B, had known that Mr D spent time alone with Child Bk and protective action was taken; Child Bk came into local authority care. Mr D was arrested with a charge of rape. He received a custodial sentence.

[24] A sexual harm prevention order (SHPO) is an order made by a court that places restrictions on a person's behaviour in order to protect the public from sexual harm. SHPOs are made under the Sexual Offences Act 2003 and can last for any length of time, depending on the specific terms of the order. SHPOs can include a wide range of restrictions, such prohibiting the person from contact with certain individuals, including children. A Comprehensive Guide to Sexual Harm Prevention Orders (SHPO) (stuartmillersolicitors.co.uk)

[25] The Sex Offenders Register is a register containing the individuals cautioned, convicted, or released from prison for a sexual offence against both children and adults since 1997.

3. Analysis and Key Finding of this LCSPR

3.1 LCSPRs are undertaken in prescribed circumstances with a focus on how well a child or children were safeguarded in the community in which they live. The goal of the LCSPR is to identify improvements to be made to safeguard and promote the welfare of children or to highlight best practice which can be more deeply embedded into practice. The Rapid Review process identified early learning and individual agencies have identified their own learning and what action is needed to respond to these. This is part of an action plan which is overseen by the Local Learning Review group. This section focusses on multi-agency learning about the local response to concerns about child sexual abuse.

- Finding 1 looks at the multi-agency professional response to adults who view images of child sexual abuse.
- Finding 2 looks more broadly at the identification of child sexual abuse and the extent to which children are supported and enabled to talk about the sexual abuse they have been subject to.
- Finding 3 focusses on the response to members of the public who raise safeguarding concerns about children.
- The conclusion focusses on the lack of multi-agency processes to safeguard Child Bk.

Finding 1: The importance of a robust safeguarding response when adults are found to have downloaded and viewed child sexual abuse images and the risks they may pose of sexual abuse to children.

3.2 The title of this finding is uncompromising. The viewing of images of children being sexually abused is a form of child sexual abuse and needs to be named as such. This form of child sexual abuse can be trivialised by those who commit these offences; this was certainly the case with Mr D, his parent Person C, and Child Bk's mother. It is important that professionals take such concerns seriously and move from seeing this activity as an extension of pornography (or calling this child pornography- although this was not an issue in this review) or 'just' the passive act of viewing of images. This form of sexual abuse is often referred to as 'online sexual abuse' or 'technology assisted child sexual abuse'[i]. It includes the viewing of children of all ages being sexually abused by others, but also the creation of content or images through coercive contact with children, or the sharing of these images with others. This kind of sexual abuse is very often perpetrated by a family member, an acquaintance of the family or a person in a position of trust. The impact on the children who are sexually abused in these images is severe and persists across their childhood into adulthood and beyond; they are often the forgotten or hidden victims[ii].

3.3 Over the years there has been an exponential growth in the sexual abuse of children to produce images and the number of people accessing them. In the UK in 2021 there was an average of over 850 arrests for accessing child

sexual abuse material every month[iii]. In 2022 the Internet Watch Foundation[iv] detected child sexual abuse material in more than a quarter of a million webpages. Of the 103,000 sexual offences recorded by the police in England and Wales in 2021/22 a third related to sexual abuse images[v]. However, the true extent of child sexual abuse committed in an online context is far higher than is being reported. It is striking the extent to which those professionals who undertook assessments or early investigative interviews with Mr D did not believe that he might sexually abuse children. Phrases such as 'they were like brother and sister' or 'Ms D has known him since she was 9 and he has never downloaded images' sought to minimise the concerns.

3.4 This review starts when the police became aware that Mr D had downloaded and viewed child sexual abuse images. It was established that he lived with his partner and young children. Mr D was interviewed, released on police bail to have no unsupervised contact with a child under 16 and to live with his parent Person C who would supervise Mr D's contact with his children. Mr D did not tell the police about his wider family and no steps were taken to seek this information. The link with Person B and Child Bk was not made. Person C had a significant history regarding neglect, domestic abuse and alcohol use. There should have been a multi-agency discussion about whether these contact arrangements were safe and appropriate.

3.5 A referral was sent to the children's MASH. This was an important further opportunity to create an ecomap[26] of Genogram of Mr D's extended family and children he was connected to and to consider what action is necessary to keep those children safe. This did not happen, and this left Child Bk and a stepsibling at risk of harm. A strategy meeting would have provided an opportunity to consider Mr D's family history, the historical concerns about Person C's neglect and abuse of children and the likely lack of boundaries around Mr D's adult behaviour. It would have made clear Person C's relationship with Person B, the link to Child Bk and Child Bk's childhood experience of neglect. This should then have led to a more robust response to all the children Mr D was connected to.

3.6 A child and family assessment of Mr D and his family was agreed. Limitations of the Bail Act (since amended in law[27]) resulted in the initial bail conditions for Mr D being removed. The police supervisor in charge of the investigation attempted to contact children services to make them aware of this, without success and there is no evidence of any escalation efforts being made. This resulted in there being no joint working about the impact of the bail conditions being removed, or any contingency plan developed. This joint working may have prompted an exploration of Mr D's wider links with other families. This Consequently, children's services asked Ms and Mr D to sign a written agreement agreeing to all contact to be supervised with the focus only on Mr

[26] An ecomap is a visual tool that helps professional to understand family relationships with their environment. It shows the how connections to various people, groups, and community, as well as the quality and intensity of those connections. It can help identify sources of support and stress, areas of need, and potential interventions.

[27] Bail | The Crown Prosecution Service (cps.gov.uk)

D's children. The original police bail conditions related to restrictions on contact with "all children", which was/is quite common in investigations of this kind where there is no specific victim identified.

3.7 What was missing from this child and family assessment was any sense of Mr D and what is termed 'his pathway to offending'. In order for professionals to understand, address and respond appropriately when there are concerns that adults may pose a risk of sexually abusing children it is important to consider the adults circumstances. This includes any stress they are under, whether there is a misuse of drugs or alcohol, the use of pornography, attitudes to women and whether there had been a recent traumatic event. There was no exploration of Mr D's circumstances or his family history. If there had been his care history would have been known and the abuse and neglect he had experienced and his wider family relationships.

3.8 There a period of 2 and a half years where Mr D's devices were on a waiting list for examination. This delay was caused by the volume of offences reported to the police at this time and the impact of this on their forensic services.

3.9 In December 2021 it was confirmed that Mr D had watched child sexual abuse images. There remained a narrow focus on Mr D's own children, rather than mapping who else he was in contact with. Ms D continued to ensure her young children were safe and so no further action was considered necessary. The needs for the safety of Child Bk and the stepsibling were not addressed. We now know that Mr D started sexually abusing Child Bk, age 11, at this time.

3.10 When concerns were raised in June 2022 about Child Bk's contact with Mr D there was no strategy meeting convened. These processes enable each agency to share information and work closely together on the shared goal of holding adults who sexually harm to account and keep children safe. The growing number of adults who have contact with children who view/download/manufacture children being sexually abused online means that there will need to be a process of prioritisation, and a decision made locally about whether a strategy discussion should be called. For Child Bk, given the histories of her family, and previous concerns of children not being safeguarded from sexual abuse in the context of neglect, and a similar history for Mr D, a strategy meeting should have been convened and joint child protection enquiries undertaken[28].

3.11 In the absence of child protection enquiries[29] in June 2022 it was agreed that a child and family assessment would be completed. This assessment lacked

[28] Where a referral indicates a potential criminal offence, there is an expectation that a joint Police and Social Work investigation will take place. Police will have primacy regarding the criminal investigation. Children's social Care will have primacy regarding safeguarding of the child. It is critical that there is considerable liaison between each agency and information shared both ways, to support the criminal investigation and safeguarding the child.

[29] Children's services have a legal duty to make enquiries if they receive information that a child may be at risk of significant harm. These child protection enquiries are sometimes called **child protection investigations**. They are also referred to as 'Section 47 enquiries or investigations.' Reference Children Act 1989. Children Act 1989 (legislation.gov.uk)

clarity in the task being undertaken. The purpose was to establish whether Child Bk had been sexually abused or was at risk of being sexually abused. There was too much reliance on the lack of concern by the police who visited Child Bk and her mother and information contained within the public protection notice (PPN[30]). There was no independent analysis based on current information and historical concerns. The PPN and the child and family assessment used euphemistic language, including "*nothing inappropriate happened'* and that *"Child Bk and Mr D were 'like siblings"* It remains unclear whether Child Bk or Person B understood that the concern was about child sexual abuse and whether the police officers or social worker articulated this clearly enough. There is no evidence that Child Bk was seen alone or that she was enabled to talk about possible sexual abuse (see Finding 2).

3.12 The assessment should also have focussed on whether Mr D posed a future risk to Child Bk. Research[vi] suggests that adults who view the sexual abuse of children online and have not been found to commit any other child sexual abuse offences pose a relatively low risk of going on to sexually abuse children. However, each set of circumstances needs to be considered and risk assessed. This risk assessment needs to take account of the circumstances and vulnerabilities of the child, to understand the potential for grooming and coercion; the likelihood and ability of the non-abusing parent to recognise that a child is being groomed and possibly sexually abused, and the behaviour of the adult of concern. It is the weighing up of these factors that count in the context of assessing the likelihood that an adult who has viewed images of sexual abuse online will go on to sexually abuse a child. This did not happen for Child Bk; there was evidence of vulnerability, she had previously been targeted online in chat rooms; she had physical health concerns, she self-harmed and had difficult friendships. Her mother had previously been found to have not been able to keep an older sibling safe from child sexual abuse and had neglected Child Bk. Children who are neglected are 5 times more likely to be sexual abused than other children[vii]. These were all signs and indicators of child sexual abuse which were not brought together to build a picture of concern. There was no weighing up of the risk factors or signs and indicators and an overreliance on Child Bk to tell professionals what was happening. This is also considered in Finding 2.

3.13 When Mr D was sentenced for viewing child sexual abuse activity in September 2022, he became subject to police offender management supervision and probation oversight. The Probation officer assessed Mr D as a medium risk of sexual harm to children and sought information about the children he had contact with. It seems that Mr D highlighted his connection with Child Bk and the probation officer found the link with the 16-year-old step sibling. Appropriate boundaries were put in place whilst checks were undertaken. This was effective practice. The probation officer was told that children's services were happy with the ongoing supervised contact

[30] A PPN is a police led information-sharing document that records safeguarding concerns about an adult or child. PPNs are shared with partner agencies to inform a multi-agency response. Public protection notice (PPN) - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)

arrangements for all the children. The probation officer should have asked more questions about this to seek to understand if this was a sound judgement based on her own knowledge of Mr D's risk status. It is the routine checking of each professionals understanding of risk based on their own professional role and knowledge that provides a rounded and overall risk assessment.

3.14 This review highlights some local professional uncertainty about how to respond when an adult has been found to have watched and downloaded child sexual abuse imagery and how to risk assess the possibility of contact sexual abuse to children, the need for eco-maps, what constitutes safe contact arrangements, what safety planning needs to be in place and how to talk to children about child sexual abuse.

Recommendations 1: The Northamptonshire Safeguarding Children's Partnership Child protection Procedures section on Online Safety, needs to be updated to include:

processes for risk assessment

the criteria for when a strategy meeting should be convened

what safe contact looks like

what safety planning needs to be in place,

what risk assessment processes needs to be undertaken.

As part of this work there needs to be:

Exploration of the barriers to professionals applying the correct thresholds to risk and subsequent convening of strategy meetings.

A review of the need to create a separate and specific pathway for children that reside in the home of those who have viewed indecent images of children.

Assurance that the Police are informed in the first instance of any awareness or suspicion that indecent sexual images of children are being viewed and any connected child(ren) are being protected.

Recommendation 2: Northamptonshire Children's Partnership should consider circulating the Home Office commissioned guidance 'Managing Risk and Trauma after On-line Offending' to all partners agencies with an accompanying brief about usage in practice.

There will need to be further consideration of how this is then incorporated into practice through training or inclusion in procedures.

3.15 In this case it as clear that Mr D's bail conditions were regularly lapsing and children's services (NCT) have no evidence that a strategy meeting was requested. This was not escalated by the police. This lack of multi-agency

understanding of bail conditions and the legislation surrounding them has been seen in a previous Northamptonshire LCSPR.

Recommendation 3: Guidance needs to be developed regarding multi-safeguarding agency responsibilities with regarding to bail conditions including communication by the police, the expectations of when strategy (meetings should be convened, the role of children's services and what action is required from all agencies.

Finding 2: the identification of child sexual abuse

3.16 This finding explores what Child Bk's circumstances tell us about the how effective was the identification of child sexual abuse and whether the professional response provided appropriate safety and support. It is clear there are several shortfalls in the professional response to concerns about possible sexual abuse.

3.17 Current research suggests that I in 10 children (15% of girls and 5% of boys) will be sexually abused before the age of 16[viii]. This is noted to be an underestimation of the likely real figure, but still represents a considerable number of children. Of these children only 1 in 8[ix] comes to the attention of services and there are wide regional variations in the number of children who are subject to child protection enquiries, assessments, or child protection registration for child sexual abuse. There is national consensus that most professionals across the safeguarding network currently lack the confidence, skills, and knowledge to support children to talk about sexual abuse, to identify concerns and respond appropriately.

Talking to children about child sexual abuse

3.18 Child Bk was not identified as being at risk of sexual abuse from Mr D until June 2022. The school made clear to the police that Child Bk had social and emotional needs that impacted on her learning and interactions with others. She did not have a diagnosed learning need, but there was recognition by the school that professionals needed to know that care needed to be taken when communicating with her. The police officer who attended the family home was not a specially trained officer; something that would not be expected on this first call out. Child Bk was seen alone. It is unclear exactly what she was asked, but the focus seems to have been on whether Mr D 'behaved appropriately'. This phraseology was completely open to interpretation for a 12-year-old with social and emotional needs. Child Bk said that Mr D always treated her with kindness. The police officer concluded that there were no concerns of sexual abuse and was reassured by the sense that Mr D and Child Bk were like siblings. It is of note that she was seen at home, with her mother present in the house. If she had been in school on that day, this might have made a difference, and enabled her to talk about her contact with Mr D. There was no account taken of likely grooming in this interview or consideration that Child Bk was meeting a stranger, and it might take more than one brief meeting for her to talk about her contact with Mr D and what

that looked like in reality. Some more exploration of the connections between a 12-year-old and a 30-year-old, beyond a family connection was required to understand what was going on.

3.19 Child Bk was also seen as part of the child and family assessment in August 2022 and the assessment says she was seen alone. At this meeting Child Bk is recorded as saying that she liked Mr D and that he was kind, a similar phraseology of the discussion with the police officer. The questioning again focussed on 'inappropriateness' without reflection of whether this made sense to Child Bk or that she understood that what was being asked was about sexual contact. The social worker made no contact with the school, so did not have a sense of Child Bk's learning needs or any adjustments that might need to be made; so, none were made. As with the police interview, the expectation that Child Bk would feel able to open up to a stranger in quite a brief interview was an unrealistic expectation. There was also a lack of reflection of whether Child Bk understood she was being sexually abused and the extent of grooming that she was subject to. There was no exploration about the time Mr D and Child Bk spent together and what they had in common given their age difference, except a family connection. The social worker did not make contact with the police to discuss what Child Bk and her mother had said. If she had, she might have noticed that Child Bk's responses were very similar. This could have suggested that she had been groomed by someone about what to say. This was not considered or discussed.

3.20 Child Bk (aged 12) attended the GP on a number of occasions between April and November 2022 with concerns about stomach upsets, headaches and more latterly vaginal infections. She was always seen with her mother. She was asked about sexual activity, despite being of an age [31] where she could not consent to this, and mother spoke for her. She needed to have been seen on her own by the GP in order to be able to discuss these sensitive issues.

3.21 Child Bk's school were proactive about talking to her about her worries. They alerted professionals to the possible risk posed by Mr D in June 2022. They were reassured by the police and children's services that no action was necessary in the belief that a full risk assessment had been completed. They noted that there was an escalation in her absences for health-related concerns. There were appropriate check-ins with her.

3.22 Overall, across the professional network there was an over reliance on Child Bk to tell professionals that she was being sexually abused by Mr D. There is considerable evidence that children face considerable barriers in talking about being sexually abused. This includes embarrassment, shame, worries about what it might mean for them and their families, not having the language and not recognising that they are being abused. Children need help to talk about abuse. They need professionals to see them on their own, to notice the child and their circumstances, to make reasonable adjustments based on language

[31] Sexual Offences Act 2003 (legislation.gov.uk)

and cognition needs and to ask questions; this demonstrates communication and listening. There was a use of euphemistic language and lack of clarity in recording and a lack of consideration of what an 'appropriate' or 'inappropriate' relationship looked like to Child Bk given her history and the likelihood of grooming by Mr D. This was not considered. There is national evidence of a reluctance to facilitate a discussion about child sexual abuse, for fear of contaminating evidence or getting it wrong. Children tell us they need this support and facilitation. The Communicating with children guide published by the Centre of Expertise on Child Sexual Abuse aims to give professionals the knowledge and confidence to speak to children about sexual abuse[x].

Identifying child sexual abuse

The current statutory child protection approach to responding to concerns that a child is being sexually abused puts ***too much responsibility*** *on children and young people to recognise the abuse they are experiencing and then to seek a trusted adult to talk about what is happening to them".*

"This is a heavy, and frankly unrealistic responsibility. Children cannot and should not be the only witnesses to the harm they experience; it is the responsibility of the adults around the child to respond to help-seeking behaviour and to safeguard them". CSA Centre Blog[xi]

3.23 There is clearly a national gap between the number of children who are being sexually abused and those being identified. Reducing this gap requires professionals to feel confident and able to use their professional judgment and build a picture of concern. The picture for Child Bk included:

- There had been a deterioration in her mental health and well being since November 2021 as evidenced by school, including self-harm, suicidal ideation and poor school attendance.
- Child Bk had been targeted by adults online.
- She had been attending her GP for concerns about abdominal pains and erratic periods.
- She had regular contact with an adult (Mr D) who was known to have watched and downloaded child sexual abuse images.
- Her mother was dismissive of the concerns, seeing them as a misunderstanding.
- There was a long history of neglect for Child Bk which started before birth. She witnessed domestic abuse and it had been found that her mother had not been able to protect an older siblings from sexual abuse by an adult known to the family. The hypothesis being this was caused by excessive alcohol use by mother.
- As has already been mentioned there was no information sought about Mr D. No curiosity about what the relationship was between him and Child Bk, why she spent time after school with someone 20 years older than her who had his own young family.

- No consideration of what was going on for Mr D that might have been understood as a 'pathway to offending'.
- No consideration of how Child Bk's mother or her partner, Mr D's parent understood the relationship and how they ensured boundaries were in place (we now know those boundaries were not in place).

3.24 All these factors were 'signs and indicators of child sexual abuse'. They were of course also signs of other kinds of distress, but child sexual abuse needed to be considered (see the Signs and Indicators template which is designed to help professionals gather the signs and indicators of sexual abuse and build a picture of their concerns[xii]). The GP practice was not aware of the detail of the referral in June 2022, so likely contextualised the health issues as related to adolescence. They could still have considered an alternative of child sexual abuse and sought further information to build a picture of concern. The GP did ask about sexual activity, but with mother present. They did not appear to have considered that at age 12 Child Bk could not consent to sexual activity and was unlikely to be able to be open with her mother present.

3.25 The social worker who carried out the assessment in June 2022 had information available to her but did not analyse it or consider that there was evidence of likely sexual abuse. The conclusion that Child Bk was not being sexually abused came from the fact that she made no disclosure as opposed to weighing up the available evidence and concluding that it was not known whether Child Bk had been abused. It is not clear why this was, beyond concerns about the quality of the assessment and the general reluctance of all professionals to consider sexual abuse as a possible concern.'[xiii].

3.26 School had a picture of a distressed child and they recognised this. They were reassured by the police conclusion that Child Bk had not been sexually harmed. They were not informed that a child and family assessment was being completed, did not know this concluded that Child Bk was safe and had not been sexually harmed and of course did not see a copy of the assessment itself. This meant they did not have a fill picture of Child Bk's circumstances. They could have sought feedback to understand decision making by the police and children's services and given they had been assigned a role to support Child Bk (without their knowledge) they should have seen the child and family assessment. This review has highlighted that there is some confusion about when child and family assessments should be shared with agencies. This is addressed as a recommendation.

3.27 The police officer who attended was provided with information by the school, so they were aware of Child Bk's recent deteriorating mental health and the family history of neglect, domestic abuse and alcohol abuse. This was a non-specialist police officer who concluded that Child Bk had not been harmed because she made no disclosure rather than building a picture of known concerns. The PPN that was sent to children's services stated definitively that Child Bk had not been sexually abused by Mr D. The concerns were closed down without any analysis or multi-agency discussions.

3.28 The child and family assessment was the critical process for analysing the available information alongside those agencies that knew Child Bk well. The assessment of Child Bk did not include information from other agencies. Despite the school knowing her well and the GP holding significant health information. The Assessment Framework 2000[xiv] made clear that child and family assessment should be multi-agency in approach, both in terms of seeking information, as well as analysing this information. It is therefore important that agencies understand what sense the assessing social worker has made of the information they have shared, and that if they have a role in any plan to respond to the child or family's needs going forward that they see a copy of the completed assessment.

3.29 Child Bk was left with the responsibility for talking about the sexual abuse she was subject to, rather than professionals making a judgement based on the available evidence. This review acknowledges that working with uncertainty is difficult. Professionals need to be supported to feel confident in working with uncertainty and feel able to make professional judgements. The Northamptonshire Safeguarding Children's Partnership procedures on responding to concerns about Intrafamilial child sexual abuse starts with when a child has told someone they are being abused, not when professionals have noticed that there might be evidence of child sexual abuse and then guiding them about how to respond appropriately. This needs to be addressed.

Sibling sexual abuse

3.30 Child Bk and Mr D clearly were not siblings, and he was an adult, she was a child. It is however, striking that they were described as 'like siblings' and this seems to have indicated to those professionals that this meant that Mr D could not be sexually abusing Child Bk. Although this was not a case of sibling sexual abuse, it indicates that professionals are not equipped to identify and assess likely sibling sexual abuse.

'*Acknowledge, address, adapt - Closing the gap between sibling sexual abuse as the most common form of child sexual abuse in our homes and the most ignored form of child sexual abuse in the UK*[xv]*'.*

3.31 The recently published Rape Crisis UK Policy report on sibling sexual abuse[xvi] highlights that sibling sexual abuse is a common form of child sexual abuse which is least likely to be identified or responded to in a way which addresses the harm, keep children safe, addresses the impact on family relationships and helps children who have been sexually harmed. As such this needs to be addressed nationally and locally.

The non abusing parent.

3.32 In identifying and responding to child sexual abuse it is important to consider the role of the non-abusing parent. When concerns were first identified in April 2019, an assessment was completed of Mr D's partner. This assessment appropriately recognised her shock and the likely impact on her wellbeing. She was noted to have taken immediate action to safeguard her young

children, asking Mr D to leave and ensuring that any contact was supervised. It is notable that Mr D moved to live with his parent, Person C, and there was some suggestion that this parent would be a suitable person to supervise contact. The reality of Mr D's early life was knowable at this time and would have made this an inappropriate choice. This was never tested because Mr D's partner decided that he should have no contact with the children, but these circumstances raise questions about the lack of focus on Mr D's parents' capacity, willingness and ability to create safety for these children.

3.33 At the outcome of the assessment for Child Bk in August 2022, her mother said that she would supervise all contact between Child Bk and Mr D. This was accepted without understanding what contact they already had and what that would look like in the future, how this would be practically achieved. There was no definition of what 'supervised contact' looks like and what the expectations were (see the recently published LCSPR for Alfie Steel which reflects on key issues around supervised contact[xvii]). This decision also did not take account of Person B's lack of understanding of the risks Mr D could and did pose or her capacity and willingness to create safety for Child Bk. The available evidence was that Child Bk's mother had minimised the concerns and it is not known whether Child Bks mother lacked information, was being coerced or groomed, could not comprehend that Mr D might sexually abuse a child or that she wilfully ignoring the risk. This is because these issues were not considered in the assessment or discussed with her.

3.34 The history of concerns about Person B's parenting were well known including historical concerns that she had not been able to keep Child Bk's sibling safe from sexual abuse; this was not acknowledged or explored. What was required was an assessment of Person B's ability to protect, to understand the risks and to keep an open mind about the possibility that Mr D might have sexually abused Child Bk or could do so in the future. A safety plan outlining the detail of the supervised contact was also needed and some monitoring of its success.

3.35 The evidence base suggests that many non-abusing parents/safe adults are in immediate denial due to shock, and this does not automatically indicate an inability to protect[xviii]. This requires effective multi-agency assessment.

3.36 It has emerged that Person B was aware that Mr D was under investigation by the police but continued to minimise the concerns. She told professionals that she understood the need to ensure that Child Bk's contact with Mr D was supervised. This was not made explicit through a written safety plan. Subsequently, during the police investigation when it was found Child Bk had been sexually abused, Person B told the police that she had left Child Bk alone with Mr D and that Child Bk had stayed overnight at Mr D's residence on her own. A charge of child neglect was considered, but given the circumstances was not pursued. Person B had not protected Child Bk, but the lack of clarity by professionals about exactly what she was protecting Child Bk from could have undermined any police investigation. The police concluded in

their single agency report that the decision not to proceed was based on Child Bk coming into care, rather than whether a crime had been committed and that this was outside of expected decision making. This review agrees with that conclusion and all agencies should think carefully about what action is appropriate where wilful neglect is identified in line with the existing criminal definition of child neglect[xix].

Understanding the behaviour and motivations of the adult of concern

3.37 In identifying and responding to an adult about whom professionals have concerns that they may sexually abuse a child, there also needs to be a focus on their behaviour, motivation, attitudes to women/authority, stresses, and sexual history to understand how sexual abuse happens in families. So, alongside an assessment of the child's needs, family dynamics and parenting, there needs to be a focussed assessment of the adult of concern. The evidence is that this does not always happen, and that men can become 'invisible' as was found in the National Safeguarding Panels work on the professional response to men in children's lives. This was the case here. Little is known about Mr D except that he experienced an abusive and traumatic childhood and was removed from his parent's care. We do not know if that brought significant instability, what his work history was or his relationships. He was invisible in the thinking about safety for Child Bk and this lack of analysis of him made keeping Child Bk safe unlikely.

Recommendation 4: This Finding highlights a lack of confidence by multi-agency safeguarding professionals in Northamptonshire in the identification of child sexual abuse, and lack of clarity how to talk to children about child sexual abuse. There needs to be a workstream developed under the auspices of the safeguarding partnership, overseen by a task and finish group, to consider how widespread an issue this is, what needs to be done about it and what work is already planned.

Recommendation 5: The issue of the sharing of single assessment outcomes and further information being shared with partners who have a continued role with the child is a national one as well as being a key issue here. The local procedure indicate the outcome should be shared but does not make clear whether the whole document should be shared to aid ongoing work and a multi-agency analysis of a child's needs. There are no legal impediments to this approach. Work needs to be completed regarding this and expectations to be made explicit in procedures and shared with partner agencies.

Recommendation 6: This review has found that the Child and Family Assessment was of poor quality, lacked multi-agency input and was superficial in its analysis of risk and need. NCT needs to consider what action is necessary to assure themselves that this is not representative of practice more widely and consider what action to take to address this.

Recommendation 7: The current practice of relying on a mother/family member to supervise children's contact with adults who pose a risk of harm and abuse needs to be reviewed, guidance developed and an approach to safety planning developed.

Recommendation 8: Work needs to be completed about a risk assessment process to consider the risks adults pose to children of sexual abuse.

Finding 3: Responding to concerns from members of the public.

3.38 In June 2022 the school received an anonymous call from an adult in the community stating that Child Bk had been seen with an adult who could be a relative, who was a 'sex offender' who was not allowed contact with his own children and this person was worried about Child Bk's safety. This information was an accurate summation of the known facts at the time. This appropriately led to the school contacting the police as they recognised this was a significant concern. They also made a referral to MASH. On receipt of referral from school, the MASH progressed the case for an assessment.

3.39 The police officer who was assigned to visit Child Bk and her mother recorded that this was a malicious call. There was no evidence that this was the case or a reflection on what 'malicious' meant. There was no evidence it was malicious in nature, and even if calls are malicious in intention, it does not mean that the concern being shared is not real. This undermined the seriousness of the situation. The evidence needs to be weighed up based on what is known or further information needs to be sought. In this case the information was accurate, and reflected what the police themselves already knew.

3.40 It is important that members of the public, families, neighbours and community leaders feel able to alert professionals when they have concerns about the abuse of a child. Those who make these referrals depend on professionals responding in a robust way, because they have no way of knowing what happens next, they are unable to challenge when they think the response does not address the concerns they have raised, as professionals are able to do through safeguarding partnership escalation processes.

3.41 This was an issue highlighted in the National review into the murders of Arthur Labinjo Hughes and Star Hobson[xx] and is something that has been noted in a number of other published reviews[xxi]. The National review recommended that '*No referral is deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager'*.

Recommendation 9: Where concerns are raised by friends and families it is essential they are not considered malicious but a robust exploration is applied to understand the appropriate response required in accordance to the threshold document.

4. Conclusion

4.1 This review highlights the importance of appropriate risk assessment processes being undertaken when concerns emerge that an adult has downloaded and viewed sexual abuse imagery. There needs to be consideration of strategy discussions, based on the known circumstances. This should consider all children about whom there might be concerns and with whom an adult has connections with. In considering the risk posed by Mr D, there was little multi-agency working, the lynchpin of effective safeguarding practice. This lack of working together had consequences for the safety of Child Bk. This LCSPR highlights the impact of silo practice and the importance of multi-agency discussions to build a holistic picture of a child's circumstances. These multi-agency exchanges are more difficult outside of established frameworks such as of child in need or child protection processes and significant resource constraints, but they are important.

5. References

[i] Child sexual abuse by adults in online contexts | CSA Centre
[ii] Child sexual abuse by adults in online contexts | CSA Centre
[iii] Armitage, R., Wager, N., Wibberley, D., Hudspith, L. and Gall, V. (2023a) "We're not allowed to have experienced trauma. We're not allowed to go through the grieving process" – Exploring the indirect harms associated with Child Sexual Abuse Material (CSAM) offending and its impacts on non-offending family members. Victims & Offenders, advance article. https://doi.org/10.1080/15564886.2023.2172504
[iv] [iv] Eliminating Child Sexual Abuse Online – Internet Watch Foundation (iwf.org.uk)
[v] Child sexual abuse by adults in online contexts | CSA Centre
[vi] Managing risk and trauma after online sexual offending | CSA Centre
[vii] Child neglect and its relationship to other forms of harm - responding effectively to children's needs: Evidence Scopes | Research in Practice
[viii] Scale and nature of child sexual abuse report | CSA Centre
[ix] Protecting Children from Harm – a critical assessment of child sexual abuse in the family network in England and priorities for action, Children's Commissioner for England, 2015.
[x] Communicating with children | CSA Centre
[xi] Don't wait for them to tell us: recognising and responding to signs of child sexual abuse | CSA Centre
[xii] Signs and indicators of child sexual abuse | CSA Centre
[xiii] "We mustn't rely on a child to tell us verbally in order to take action" | CSA Centre
[xiv] assessing_children_in_need_and_their_families_practice_guidance_2000.pdf (ioe.ac.uk)
[xv] SARSAS SSAP Policy Report_10037.indd
[xvi] SARSAS SSAP Policy Report_10037.indd
[xvii] CSPR-Worcestershire-Alfie.pdf (safeguardingworcestershire.org.uk)
[xviii] Still, J. (2016) Assessment and Intervention with Ms and Partners Following Child Sexual Abuse: Empowering to Protect; Jessica Kingsley Press.
[xix] Child Abuse (non-sexual) | The Crown Prosecution Service (cps.gov.uk)
[xx] Child Protection in England - May 2022 (publishing.service.gov.uk)
[xxi] CSPR-Worcestershire-Alfie.pdf (safeguardingworcestershire.org.uk)