Report of the Serious Case Review regarding

Family C

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1 Introduction

1.1 This is a serious case review which was commissioned by a Local Safeguarding Children's Board in 2016. The case focuses on the neglect and suspected sexual abuse of three children under the age of 14.

1.2 This review covers 5 local authority areas and centres on the practice in local authority area 5, where the children became looked after.

1.3 The key themes emerging from this review include:

- Professional curiosity
- Understanding neglect
- Understanding sexual abuse
- Working with resistant and avoidant parents and the need for authoritative and assertive child protection practice
- Working with fathers

2 Reason for the Review and its Methodology

2.1 This Serious Case Review (SCR) was commissioned by LA5 Safeguarding Children Board, in 2018 and relates to a family who were resident in LA5 at that time.

2.2 The incident that led to the commissioning of this SCR involved three children under the age of 14. This is a case involving a history long-term abuse and neglect. The children who became looked after were subsequently abducted from a contact centre by their father while attending supervised contact on a Saturday afternoon. There was a known risk of 'flight' during contact, therefore three contact supervisors attended to minimise this risk.

2.3 SCRs are always carried out by former Local Safeguarding Children Boards (LSCBs), now known as Safeguarding Partnerships, when a child dies, or is seriously harmed, and abuse or neglect is known or suspected. Serious Case Reviews are a statutory requirement and must be completed in accordance with the guidance and expectations set out in the Government guidance, '*Working Together to Safeguard Children*' 2015, chapter 4 and the DfE transitional guidance published July 2018.

2.4 This report summarises the findings from the SCR that was established to consider the professional interventions in respect of a family, identified for the purpose of this review as the Cape Family, whose children were harmed whilst in the care of their parents.

2.5 In brief, this case concerns 4 children who became known to LA5 Children's Social Care in 2017. The children were made subject to Police Protection by the Local Authority and LA5 Police force, after being abducted by their parents. The children were found and placed in Local Authority Care where they remain. Historically, the children had moved with their

parents between several different Local Authority areas prior to this time. The focus of this review relates to the challenges of working with aggressive, avoidant and highly mobile families and the impact of this avoidance and mobility in effectively safeguarding the children.

3 Terms of Reference

3.1 Due to ongoing complex criminal proceedings it was agreed, in consultation with the Police, that the terms of reference for the SCR and the contents of this report would focus upon professional learning only and would not contain any information relating to the case.

3.2 The following terms of reference were agreed for this case:

1. When there are safeguarding concerns about children how effective is the process for alerting Local Authorities when a family unexpectedly leaves the local area and their whereabouts are unknown? How do local authorities respond to alerts, for how long and how are family names recorded on systems?
2. What is the process and rationale for closing cases when a family are un-cooperative and there is no engagement in processes and there are safety concerns for the children of the family? Were local procedures followed by individual Local Authorities in this case?
3. When a referral was made into LA5's MASH Team about concerns relating to children at a named address- how robust were the internal and external information checks and enquiries across the partnership in establishing what was known about the children? Why were education records not seemingly accessed, which would have identified children living at the specified address?
4. In agreeing to contact arrangements outside of office hours to meet individual children and family needs how robust are procedures and protocols? Are working practices safe for both workers and children?

4 Findings

Key line of enquiry 1: When there are safeguarding concerns about children how effective is the process for alerting Local Authorities when a family unexpectedly leaves the local area and their whereabouts are unknown? How do local authorities respond to alerts, for how long and how are family names recorded on systems?

4.2 Finding 1

4.3 The process for alerting Local Authorities when a family unexpectedly leaves the local area and their whereabouts are unknown was not effective in this case. Despite an alert having been made by one local Authority (LA3), this did not lead to any action being taken by the two subsequent Local Authorities (LA4 and LA5) where the family moved to.

4.4 When a family with children subject to a child protection plan moves to another local authority area, the originating authority, in this case LA1 should notify the receiving authority at the earliest opportunity. The originating authority should provide the receiving authority with the following documentation:

4.5
- Copies of an up to date assessment of each of the children in the family which clearly identified the risk(s) to each child;
- Copies of the minutes of all of the child protection conferences and child protection plans relating to the current period for which the children have been subject to a child protection plan;
- A copy of the current child protection plan;
- an up to date case summary setting out both the current situation and all relevant background information about the children.

4.6 This family had several indicators of risk including being
- A family not registered with a GP;
- Children missing from a school roll or persistently not attending;
- Information held across a network of agencies with no single agency holding the whole picture of a family history

4.7 The period of practice in LA1 was pivotal for several reasons. Firstly, this is a period in which the members of the family are engaged with universal services; for example, the school-aged children are enrolled at school, even though their attendance is poor and erratic; the family are registered with a GP surgery and there is contact with community health services through the children's school and health visiting service. Secondly, in this period there was an opportunity to work with the family, when the father agreed to a home visit; unfortunately, this visit needed to be rescheduled by Children's Social Care in LA1. From this point forward, in this case, the father becomes more guarded increasingly avoidant and controlling of interventions with his family.

5. Finding 2

What is the process and rationale for closing cases when a family are uncooperative and there is no engagement in processes and there are safety concerns for the children of the family? Were local procedures followed by individual Local Authorities in this case?

5.1 The rationale for closing the case in LA1 and LA2 was that father refused to engage with Children's Social Care and there was an unwillingness to escalate the case to the Public Law Outline. This may have been due to a perceived lack of evidence of significant harm. Also, the family left the LA areas before the case could be escalated.

5.2 The process for closing the case and alerting other local authorities was not robust and did not follow agreed procedure. The possible explanation for this was that the nature of the risks and actual harm being experienced by the children was not fully understood by professionals.

5.3 In LA3 there is evidence that the work was hampered by several errors in thinking:

1. *The start again syndrome*: "where social workers pay insufficient attention to the history of the parents and patterns of risk in the cases."[1] The work in LA3 was seen by

[1] Ferguson Harry (2016) *How Children Become Invisible in Child Protection Work: Findings from Research into Day-to-Day Social Work Practice, British Journal of Social Work* (2017) 47, 1007–1023

Children's Social Care as an opportunity to "begin anew." For example, the closure summary from LA3 notes "It is understandable that father has a mistrust of professionals given the involvement of LA1. However, whilst an opportunity existed to have a different experience in LA2, further assessment has not been agreed to." The reference to a different experience was focused on the needs of the father and not what was happening for the children. There was no evidence that the children's lived experience of care had improved or that the risks were understood.

2. *The Rule of Optimism*: which 'is where a positive stance is taken of a child's circumstances or level of risk, which is not necessarily supported by the objective evidence or information available.'[2] The closure summary from LA3 notes:

The initial concern about the new-born baby's lack of weight gain appears no longer relevant. The GP has confirmed he has no concerns about new-born's current weight now over 50th centile. It has been assessed that the 5-year-old child still has an outstanding need for a speech and language review to rule out any developmental deficit which may be relevant. It is hoped this can be pursued through health services.

The closure summary refers to being "reassured" and expresses a hope that "Elective Home Education Services will be engaging with the family in the future." The expectation that the father would voluntarily engage with EHE services was spurious, all the evidence and history in this case demonstrated the father's resistance, hostility and refusal to engage with services.

3. *Disguised compliance*: The father lied about the fact that the children were registered with the EHE team and the children were registered with GPs and Education services. When these facts were checked it was clear that these registrations only took place immediately before the visit by LA3's Social Workers. Brandon et al (2008) in an analysis of disguised compliance in SCRs, note that "Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents made it difficult for professionals to see children or engineered the focus away from allegations of harm, children went unseen and unheard."[3]

5.4 What sense did agencies make of the level of the father's avoidance and hostility? In the IMRs from LA1, LA2 and LA3, there is no working hypothesis of what was happening to the children in this family or analysis of the severity of the harm they were experiencing. When encountering high levels of resistance and avoidance, practitioners must assume that there is a rational explanation for this behaviour and must seek to understand the reasons for the resistance and address these, whilst keeping the safety and well-being of children at the centre of the work.

5.5 In LA1, LA2 and LA3 the threshold for serious harm had been met or was being investigated. It is clear that there is a suspicion of neglect but there is no working hypothesis regarding the high level of resistance and avoidance of services, to the detriment of the children's health and well-being.

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[2] ibid

[3] Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. (2008) '*Analysing child deaths and serious injury through abuse and neglect: What can we learn? A biennial analysis of Serious Case Reviews 2003– 2005'*. Nottingham, Department of Children, Schools and Families

5.6 Effective safeguarding requires practitioners to think the unthinkable. In this case all services experienced the father as domineering, demanding and threatening. There does not seem to be any consideration given to how his children and the mother experienced him, nor the impact of his behaviour on their development and their physical and emotional well-being.

5.7 A critical question is what child protection agencies including health, education and children's social care do when they are met with the level of resistance and hostility encountered by practitioners in LA1, LA2 and LA3?

5.8 In these situations, safeguarding agencies must seek for evidence of sufficient safety and good enough care within the family, to justify the decision not to escalate their concerns and child protection activity. It was impossible to come to a conclusion regarding the safety of the children because the father refused to allow social workers and other professionals to see the children alone to accurately make an assessment and gather the evidence required.

5.9 In each Local Authority there was evidence of escalation to a point. For example both LA1 and LA2 progressed the case to a Section 47 investigation and in LA3 a Police welfare check was undertaken; however, the children were not seen without the father being present, and he controlled what was seen and understood by professionals about his family. There was an unwillingness to progress the case to Public Law Outline, which would have placed the concerns within the legal arena and compelled a higher level of cooperation from the father.

6 Finding 3a

Key Line of Enquiry: When a referral was made into the Local Authority (LA5) MASH about concerns relating to children at a named address- how robust were the internal and external information checks and enquiries across the partnership in establishing what was known about the children? Why were education records not seemingly accessed, which would have identified children living at the specified address?

6.1 From LA5 Guidance, available at the time, the expectation is that the EHE team with parents at an informal meeting to discuss their plans to educate the children.[4] This informal meeting did not happen. The initial meeting with the family was not followed up with a further meeting, and information from this meeting was not shared with MASH. The action taken by the EWS and the EHE team was not sufficiently robust.

6.2 Under section 7 of the Education Act 1996, parents have a duty 'to cause the child to receive efficient, full time education suitable to his/her age, ability and aptitude and to any special educational needs he/she may have either by regular attendance at school or otherwise'.[5]

6.2 Statutory Guidance from the Department for Education, available at this time, reminds Local Authorities of their duty under section 436A to make arrangements to

[4] LA5 Elective Home Education Guidance for Parents 2017, p. 2

[5] Elective home education, Departmental guidance for local authorities, DfE, published 2017, updated in April 2019, p. 15

find out so far as possible whether home educated children are receiving suitable full-time education.

6.3 The visit was not sufficient to test that the children were in receipt of "efficient, full time education suitable to [their] age, ability and aptitude and to any special educational needs…" and a follow-up meeting was required. Although a follow-up meeting was offered it was not provided. Further, no information regarding the visit was provided to the MASH team. When considered alongside the anonymous information documented on the Council's database, and the behaviour of the adults at the time of the interaction, it may have been appropriate to submit a referral to the MASH at this stage.

6.4 There was information held within Local Authority (LA5) education systems regarding the family, but the MASH did not check these systems despite having access to them. The rationale for this is unclear. The procedure has been changed to ensure that all relevant information systems are now accessed.

Finding 3b

6.5 The MASH team's response to the anonymous contacts regarding the children was not robust. There is no evidence that the MASH team followed up with the EWS or the EHE Team the outcome of their visit to the family. The information checks by the MASH team and the EWS and EHE were inadequate. There is no evidence of joined up work between the MASH and the EWS and EHE teams. Also, as noted above, it was the MASH team's responsibility to request a Police welfare check; however, this was passed to the referrer.

6.6 The internal and external information checks were not robust. Internal education systems should have been accessed by the MASH and the MASH should have had a discussion with the Police rather than expecting the referrer to do so. This could have led to a timelier protective response for the children.

7 Finding 4

Key Line of Enquiry: In agreeing to contact arrangements outside of office hours to meet individual children and family needs how robust are procedures and protocols? Are working practices safe for both workers and children?

7.1 In arranging contact, workers were aware of the risks of flight; as the father had previously fled with the children. The arrangements for contact therefore included three contact workers. In addition, throughout the work with this family the father was highly resistant and avoidant and unwilling to cooperate with statutory services. The possibility of abduction should also have been considered as part of the plan to keep the children safe. This risk should have been assessed and contingencies, such as a safety plan, should also have been put in place.

Analysis and Lessons

8 Work with avoidant, aggressive and hostile families

8.1 This is a case of a highly avoidant, aggressive, resistant and hostile family who went to extreme lengths to ensure that services were unable to hear, see and learn from the experience of the children, enabling services to ensure that they were safeguarded. The evidence from agency reports and case files was that the father was a dominant and controlling personality; who was suspicious and avoidant of statutory services. The father refused to engage with interventions because he did not want to; he did not want services to see, hear, or understand what was happening to his children and he did not want services to intervene. Practitioners needed to make sense of his extreme avoidance of statutory services.

8.2 One of the key facets of the multi-agency work with this family, over an extensive period of time and across multiple local authority areas is that no professional or service was able to put forward a clear hypothesis of what could be happening to these children and why the father was so avoidant, aggressive and ultimately evasive. There was no analytical, child-centred reflection on what was driving this behaviour.

8.3 A clear hypothesis regarding potential harm, the willingness to think the unthinkable led to decisive and authoritative action.

8.4 It should have been recognised that the father was an involuntary service user and that he would not willingly engage or participate in interventions with his family.

8.5 This required what, Professor Harry Ferguson describes as, the use of 'Good authority' (Ferguson 2011). According to Ferguson, good authority requires three things

- "a model/conceptual framework that clarifies its nature, role, ethical dimensions, appropriateness and methods of application
- An analysis of the relations of authority with the organization and their impact on how frontline staff feel about and exercise authority
- An understanding of one's own personal relationship to authority."[6]

8.6 All agencies that came into contact with the father and his family became concerned about the welfare of his children. However, agencies struggled to engage the father and to see and understand the experience of his children.

8.7 A feature of this case was a lack of clarity about professional authority and an apparent lack of knowledge and skills in how to manage non-co-operation. The father was allowed to hold services at bay by avoiding them, appeasing them through disguised compliance, intimidating them with a barrage of complaints and threats, and ultimately, evading them by leaving the local area.

8.8 Ferguson goes on to present a model of what he calls 'authoritative negotiated child protection'. The model consists of the following 8 steps

1. Recognise authority and assume conflict and not cooperation

[6] Ferguson, Harry, (2011) *Child Protection Practice,* p. 171, Palgrave Macmillan

2. Encourage openness and honest expression of feelings
3. Identify what the resistance is really about and what is working well
4. Identify dangers to the children
5. Identify what is not negotiable
6. Identify what is negotiable
7. Formulate a child protection plan
8. Be clear about criteria for progress[7]

8.9 Had the father been met with practice that was aligned to the model described above in LA1, it is highly possible that the outcomes for this family may have been different. This is not to criticise LA1 but to highlight the need for clarity and urgency when working with hostile and aggressive parents or carers. Practitioners must quickly understand what is driving the hostility and aggression and formulate a child-centred, protective response. Effective management oversight and supervision is critical to enable this.

8.10 What was needed in this case was reflective management supervision and oversight that enabled practitioners to reflect on their feelings and the impact of the father. Ferguson's work highlights this, and it is important to quote him at length when he notes,

8.11 What is clearly needed are supportive systems that are emotionally aware. This is particularly important if the complex dynamics of pathological communication or danger are to be brought to the surface and combated. Workers' sense of safety or danger must be seen as a key measure of child safety. Organizations, managers and case supervisors need to give attention to all the emotional dynamics and relations of authority… Workers' feelings need to be at the centre of this, not simply so that their concerns for their own well-being can be addressed, but because their emotional experience provides crucial data about what the children are feeling and experiencing. If workers don't feel authoritative and safe, the strong likelihood is that the child is not safe either.[8]

8.12 This case raises the need for authoritative practice. Authoritative practice is not authoritarian, coercive or oppressive to service users, but it is practice which includes

- a clear focus on the desired outcomes,
- sets clear expectations regarding behaviour from parents and other adults in the family network including how breaches should be responded to
- ensures that the CP plan is not simply a list of concerns, but the plan clearly identifies risks, the parental responses that are needed to address these risks and the required outcomes for children to be safeguarded and their welfare promoted.
- Authoritative practice follows through when the needed response/required outcome does not happen
- ensures contingency planning occurs through a legal planning meeting in which the thresholds for court action are clearly identified and progressed in a timely way[9]

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[7] Ibid, pp.174-178

[8] Ibid p. 179

[9] *Authoritative Child Protection Practice Quick reference guide* Essex Safeguarding Children Board 2011

8.13 Authoritative practice means that professionals are aware of their professional power, use it judiciously and that they also interact with clients and other professionals with sensitivity, empathy, willingness to listen and negotiate and to engage in partnerships. They respect client autonomy and dignity while recognising their primary responsibility is the protection of children from harm and the promotion of their well-being.[10]

8.14 What were the bottom-line expectations in this case? What were the known, evidence-based risks and harm to the children (including how these were understood by the professional network)? What were the bottom-line expectations of good and safe parenting and what needed to change in the care-giving response of parents? What were the contingency plans if these expectations were not met?

8.15 This review has highlighted the need to follow agreed procedures and processes especially in respect of children going missing during a section 47 investigation and how this should raise the level of urgency and concern.

9 Elective home education and Safeguarding children

9.1 Parents who elect to home educate their children are not more likely to harm or abuse their children. However, it is essential that the law and guidance in relation to EHE is known and understood and that there are processes in place that enable the local authority and partners to be assured regarding the quality and sufficiency of the education being provided to children and that children who are being home educated are safeguarded from abuse and neglect.

9.2 An NSPCC (2014) report analysing the findings of serious case reviews where EHE was a key factor, found that children died, or were seriously injured, as a result of

- Neglect and / or physical, emotional and sexual abuse
- Malnourishment and severe wasting
- Suicide
- Substance poisoning caused by Fabricated or Induced Illness (FII)

9.3 The themes identified in the 2014 research paper published by the NSPCC into SCRs where EHE is a key factor resonate with the findings of this SCR. This includes the following themes

- **The child's invisibility and isolation:** The isolation and invisibility of home educated children was flagged as a serious issue in most of the SCRs.[11] In this case, professionals struggled to see and hear the children.
- **Dominant personalities of parents / carers:** Four of the case reviews identified parents / carers who were extremely well-informed, articulate, hostile, aggressive and/or resistant to professional intervention. Their attitudes and approach intimidated professionals and diverted the focus away from the children's welfare. The SCR reports found that they had used home education to avoid scrutiny of their childcare and were able to control, monitor, limit and / or deny

[10] Essex Safeguarding Children Board (May 2011) *Authoritative Child Protection Practice: Quick reference guide*, May 2011 Adapted from Jane Gilgun

[11] NSPCC *Home education: learning from case reviews What case reviews tell us about elective home education* March 2014, p. 1, Copyright © 2014 NSPCC Information Service - All rights reserved.

access to the children.[12] The father was dominant and over-bearing. The mother presented, to some extent, as a victim of coercive control herself. One of the features of this review has been the limited voice of the mother in the care of her children and the response to agencies. All of the evidence points to the fact that the father wanted to limit and deny access to his children because they were experiencing neglect and abuse.

- **Professionals' understanding of their own and each other's roles and responsibilities with regard to the safeguarding of home educated children:** Education Other Than At School services (EOTAS) are offered to parents who choose to educate their children at home. Professionals did not have the necessary knowledge or skills to address safeguarding concerns. This was compounded by children's social care staff's lack of awareness of the limitations of home education legislation. They also made assumptions about the depth and adequacy of the safeguarding and welfare component of the EOTAS assessment process that impeded their professional judgement and decision making.[13] In this case, it is clear that whilst the EHE Team had an understanding of their role, they were not rigorous in seeking assurance regarding the safety and well-being of the children and they did not complete their stated follow-up visit.
- **The health care of home educated children:** Children educated at home do not have access to school nursing services. School nursing services may be the first to detect children with health problems and identify those whose immunisations and routine health checks are not being followed up.[14] The health of the children in this family remained a concern throughout this case.

10 Harmful Beliefs and Religious Practice

10.1 This family were deeply religious. The children were warned to not speak to the authorities, which were labelled as 'demonic'.

10.2 In this review it is unclear if the father's understanding of the Christian faith was a causal factor in the neglect and abuse his children experienced. However, there is limited information about the nature of the father's religious beliefs and how these beliefs shaped his understanding of the parenting task and what was required to keep his children safe.

10.3 It is essential that a family's faith and beliefs are fully explored in assessments; especially in relationship to the safety and well-being of children.

10.4 A related issue is how statutory services engage with the safeguarding leaders in faith communities. In this case the father was able to attend the church his children attended when they were in foster care. This should have been part of the looked after child plan and work should have been done with the leaders at the church to manage this safely.

[12] Ibid, p. 2
[13] Ibid, p. 2
[14] Ibid, p. 3

11 The organisational and systemic issues which impacted on practice

11.1 The monitoring visit by Ofsted, notes that, "Senior managers have identified and begun to address serious weaknesses within the multi-agency safeguarding hub (MASH)…"

11.2 The organisational challenges in the MASH found by inspectors are, to some extent, borne out in this case. The referral did not receive an appropriate response. Also, the visit of the EHE team and the EWO was not followed up by the MASH team.

12 Working with suspected sexual abuse

12.1 Throughout this review, there was an undercurrent of suspicion regarding the harm being experienced by the children. Every professional or agency that encountered this family sensed that there was something unsafe happening with these children in relation to their health, education and emotional well-being.

12.2 It was only when the father was arrested that professionals were able to assess the lived experience of the children. It is clear that the children were living in conditions that were neglectful, their home environment was described by the Police as being "…in darkness and… very dusty and dirty", their educational needs were not being met and their presentation suggested that the father was entirely dominating and possibly abusive.

12.3 When the children were taken into Local Authority care there were several disclosures that indicated intra-familial sexual abuse.

12.4 It is noteworthy that this information was included in the IMR provided by the Police but is not referenced in any of the other agency's IMRs.

12.5 The IMR provided by children's social care notes
Although the children remained safe in placement, the earliest opportunity for investigating an allegation of interfamilial sexual abuse, planning and co-ordinating the safeguarding of the children in partnership with Health and Education was not taken.[15]

12.6 The children were interviewed but no disclosures were made.

12.7 In safeguarding children, the evidentiary burden is the 'balance of probability' as opposed to the burden of proof in criminal cases which is 'beyond reasonable doubt'.

12.8 It is a feature of intra-familial child sexual abuse that interventions are often driven by disclosures and then are primarily led by the Police.

12.9 The findings from Ofsted's joint targeted area inspections (JTAI) of '*the multi-agency response to child sexual abuse in the family environment*', found that

Practice in this area is too police-led and not sufficiently child-centred. Too often, health agencies are not involved at all. Police often led decision-making in cases of sexual abuse in the family. This was because of a lack of confidence and ability to challenge within the rest of the partnership. We saw too much silo working and, in most of the work we saw with children, not enough involvement from health professionals due to children's social

[15] LA5 Children's Social Care IMR

care and the police not consistently involving health partners in decision-making. This meant that decisions were made without all of the information and that children were then left at risk and/or without medical treatment[16]

12.10 Professional responses to the possibility of sexual abuse are, far too often, dependent upon a clear disclosure from children. The challenges with disclosure-led responses has been highlighted in a 2015 report by the Children's Commissioner; which notes, Children may not seek help for abuse, as they are worried about the consequences of service intervention for themselves and other family members, and they may have been threatened by the perpetrator……. Disclosure-led approaches are demonstrably failing the majority of victims of child sexual abuse in the family environment. Where there are concerns and suspicions, levels of knowledge and confidence among professionals in all sectors on how to progress concerns may vary. Some professionals are hesitant to seek information or clarification from a child for fear that such actions will be construed as 'leading the victim' and encouraging a false or inaccurate account, jeopardising the potential outcome of the criminal justice process.[17]

12.11 The Ofsted deep dive into '*the multi-agency response to child sexual abuse in the family environment*' found that
Verbal disclosure by children is rare, so professionals and other responsible adults need to be able to spot the signs of possible abuse and take appropriate action. The nature of disclosure as a process means that some disclosures are partial, and more detail may emerge over time. The details of the abuse will largely be missing when disclosure is communicated through behaviours or other signals.[18]

12.12 Inspectors also note
Just because children have not verbally disclosed the abuse does not mean they have not disclosed. Many children do not 'tell' in a straightforward way; rather, their behaviour and demeanour or the characteristics or behaviour of care-givers indicates that something is wrong. In the same way in which a child might not disclose any other form of abuse, such as neglect or emotional abuse, professionals can still work to uncover or protect the child from sexual abuse without a verbal disclosure from the child themselves.[19]

12.13 Much of the information we have about the harm experienced by the children in this family can be seen and understood with the benefit of hindsight. In the 'tunnel of practice', identifying and assessing child sexual abuse is highly skilled and complex work. Authors Howath and Platt (2018), highlight the fact that in cases of intra-familial child sexual abuse, "Decision-making in the initial stages is complex: so often it is unclear whether the child is currently at risk of suffering harm, statements may be ambiguous, and the child may be living in a context where they are being silenced, or there is uncertainty about how possible abuse may be viewed."[20]

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[16] Ofsted (2020) *The multi-agency response to child sexual abuse in the family environment Prevention, identification, protection and support* , p. 5, Published**:** February 2020 Reference no: 190046
[17] The Children's Commissioner (November 2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action*
[18] Ofsted (2020) *The multi-agency response to child sexual abuse in the family environment Prevention, identification, protection and support* , p. 21, Paragraph 72, Published**:** February 2020 Reference no: 190046
[19] Ibid, p. 23, paragraph 80
[20] Jan Horwath and Dendy Platt eds (2018) *The Child's World: The Essential Guide To Assessing Vulnerable Children, Young People and Their Families,* 3rd Edition, pp. 449-450, Jessica Kingsley Publishers London and Philadelphia

12.14 In addition to this, Ofsted highlight the need for professional confidence, knowledge and skills in cases of child sexual abuse and report that "… We found that a significant number of professionals' lack confidence in talking about sexual abuse within the family environment and do not have the skills and knowledge they need for this. One of the consequences of this is that sexual abuse is not identified as the main risk for the child. Instead, the focus is steered towards other abuse, such as emotional harm or neglect. This can then be recorded in child protection and children in need plans and multi-agency planning therefore does not always focus enough on reducing the risk of sexual abuse and planning for the future."[21]

13 Recommendations

13.1 This is a case of an abusive and dominating father who went to extreme lengths to prevent agencies from identifying and assessing the neglect and abuse experienced by his children. When professionals were able to commence assessments the father would use a range of avoidance strategies including:

- Cancelling appointments
- Not attending meetings
- Refusing to engage with assessments and other child protection activity
- Pretending to comply with requests or complying at the last minute
- Using threats and intimidation in the form of vexatious and persistent complaints
- Moving out of the local authority area

In cases such as these it is essential and potentially life-saving that there is strong and effective multi-agency working and coordination. This review makes the following recommendations in order to improve the quality of multi-agency safeguarding practice.

13.2 Recommendation 1

The Safeguarding Children Partnership should seek assurance from Children's Social Care that all contact arrangements include a risk assessment for child abduction and contingency plans.

13.3 Recommendation 2

The Safeguarding Children Partnership should seek assurance that all practitioners are skilled at working with resistant aggressive and avoidant families and that this is supported through appropriate supervision and practice development. This should include demonstrable development in authoritative practice and the skilled and judicious use of professional authority as evident through supervision and professional development.

13.4 Recommendation 4

[21] Ofsted (2020) *The multi-agency response to child sexual abuse in the family environment Prevention, identification, protection and support* , pp. 23-24, Paragraph 83, Published: February 2020 Reference no: 190046

Partners should seek assurance that arrangements regarding Elective Home Education and safeguarding are sufficiently robust and that there is effective information sharing with the Children's-Single Point of Access (C-SPA)

13.5 **Recommendation 5**

Partners should ensure that arrangements in the C-SPA are robust especially in relation to responding to referrers and requests for Police welfare checks.

13.6 **Recommendation 6**

Partners should consider the development of a Child Sexual Abuse strategy, which is focused on recognising and working with child sexual abuse within the family.

This strategy should:

- Include more than a disclosure led approach.
- Develop knowledge skills and confidence across the workforce in identifying and working with situations where child sexual abuse is suspected and may be being communicated through behaviours or other signals from the child indicating that something is wrong.
- Include clarity regarding the role of health practitioners and the use of medical examinations.
- Specify within multi-agency procedures that a practitioner from the Sexual Abuse referral centre should be invited to attend strategy discussions where child sexual abuse is a concern.

13.7 **Recommendation 7**

Partners should work with the faith and voluntary sector to seek assurance that safeguarding leads within these organisations are supported to be part of the team around the family and are included, where appropriate, in child protection, child in need and early help interventions.

Recommendation 8

Partners should seek assurance that assessments include an understanding of the family's beliefs and their impact on parenting and the possibility of including faith communities in the team around the family