Children – H and I

Local Safeguarding Children Practice Review

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Family Composition and key

The list below is of individuals referred to in the report and the identifiers used to provide anonymity.

Child H	- male subject child
Child I	- female subject child
Half-sibling 1	- eldest child of mother
Half-sibling 2	- 2nd eldest child of mother
Half -sibling 3	- 3rd eldest child of mother
Mother	- the mother of child H, child I and their three older half-siblings.
Male 1	- mother's partner prior to 2000 and father of half-sibling 1 and 2
Male 2	- mother's partner between 2000 and 2002 and father of half-sibling 3
Male 3	- mother's partner from 2004 to 2011 and father of the subject children
Male 4	- mother's partner in 2012/13
Male 5	- visitor to household around 2014
Male 6	- Mother's partner in 2015/16
Male 7	- Maternal grandfather
Male 8	- Maternal great uncle

1. Brief background and circumstances leading to the review

1.1. The children who are the focus of this report, and referred to as Child H and Child I, are the youngest of five children, their older half-siblings (referred to as half-siblings 1, 2 and 3) all being adults at the time of the review. They are members of a large extended family, many of whom have also been known to agencies for several years. Agencies have had considerable levels of engagement with the family for many years and mother herself had a history of abuse as a child. Concerns for the subject children and/or their siblings are recorded from 2000.

1.2. Concerns centred on:

- emotional harm
- physical injury
- potential risks from sexual offenders in the extended family,
- concerns about risk from mother's partners;
- general concerns about mother's parenting ability and neglect; and
- relationships and violence within the family;

1.3. Children of the family were subject to Child Protection Plans[1] from August 2010 to July 2012, due to concerns re emotional harm, and were supported via Child in Need Plans[2] and via a lead professional at different times. In addition, significant levels of support have been provided by the schools the children attended and by health visiting services.

1.4. This review was prompted by the discovery of serious sexual offences having been committed by the mother and a former partner, Male 4, against Child I. These offences only came to light in 2021 but took place in 2013.

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[1] A child protection plan is put in place following multi-agency agreement that without it there is a risk of harm. The overall aim of the child protection plan is to: ensure the child is safe and prevent them from suffering further harm; promote the child's welfare, health and development; and support the family and wider family members to protect and promote the welfare of their child provided it is in the best interests of the child.

[2] The Children Act 1989 defines a Child in Need as in need if: *He/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a Local Authority; His/her health or development is likely to be significantly impaired, or further impaired without the provision for him/her of such services; He/she is disabled. A plan should set out the support to be given.*

The Partnership[3] established the review in order to identify any learning from practice at that time, and to satisfy itself that any practice deficits were no longer present within current practice. It was of concern that these offences took place within the context of extensive multi-agency involvement with the family.

2. Terms of Reference and methodology

2.1. This review was commissioned by the Cheshire East Safeguarding Children's Partnership following a Rapid Review, completed over two meetings, in June and July 2021. An independent author was appointed but subsequently had to withdraw on realising they had had prior involvement with the case. Progress was delayed pending the identification of another author, Jane Booth, in September 2021. She is self-employed and has never worked for any of the agencies in the area.

2.2. A Practice Review Panel was established comprising senior representatives from relevant agencies (see Appendix 1 for membership) and they set out the terms of reference for the review (see Appendix 2). They have been responsible for ensuring their agencies fully participate in the review and have provided oversight and quality assurance of the review process.

2.3. The review used a blended methodology including a desk-top review of data gathered via chronologies from agencies, engagement with some practitioners via a virtual learning event, and individual interviews with some practitioners. An internal police review placed some limitations on discussions with practitioners in respect of some specific matters but did not significantly impact on the review.

2.4. The review has also been informed by the outcome of two police reviews looking at internal processes, one in Cheshire and one in West Mercia.

2.5. In addition, an audit of current cases, where risks of intergenerational sexual abuse are a factor, has been carried out to test the quality of more recent practice.

2.6. The time span for the period under review runs from 2006 to 2021. The Panel identified key safeguarding practice episodes to be considered in detail together with key lines of enquiry.

[3] The Cheshire East Safeguarding Children's Partnership was established in accordance with governmental guidance - Working Together 2018. Accountability for its effective functioning sits with three lead partners – the Local Authority, the Clinical Commissioning Group and the Police.

2.7. It was not possible to meet with members of the family for fear of compromising their status as potential witnesses in criminal proceedings. The children H and I themselves were very young when the abuse occurred and many years have passed since then. The discovery of the offences, subsequent arrest, remand in custody and eventual conviction of their mother, and the commencement of care proceedings has been traumatic for them and the Panel decided it was not in the children's interests to seek their engagement with the review at this time. This was kept under review as it had been hoped that it would be possible to include family contributions and learn from their experience once the trials had been completed. Unfortunately, a new line of enquiry emerged and new investigations commenced so this was still not possible.

3. Parallel Proceedings

3.1. Criminal proceedings re the 2013 offences were running in parallel with this review in connection with mother and Male 4. This process was managed by West Mercia police, not the local police force. Good communication was established with the Senior Investigating Officer and consultation arrangements established with the Crown Prosecution Service to ensure neither process compromised the other. Mother and Male 4 were convicted of serious sexual offences and are now serving substantial prison sentences.

3.2. A local police investigation was underway in connection with Male 3 and further alleged offences involving indecent images. In addition, towards the end of this review, further disclosures of alleged abuse resulted in a new investigation being commenced in Cheshire in respect of mother and Male 4.

3.3. The children were subject of Care Proceedings during the course of the Review.

3.4. Two police internal reviews were also underway. The first in the West Mercia's force regarding the delay in completing the digital forensic analysis of phone images which showed the abuse of the children by mother and her then partner.

3.5. The second police review in Cheshire was in respect of the response to chat-room concerns re abuse of a child in 2009.

4. Practice linked to key lines of enquiry.

4.1. As early as 2004 there had been concerns about maternal grandfather's contact with the older children; half-sibling 2, then aged 6 years, had been taken to the GP in 2005 following what mother believed to be blood stains in her knickers. Mother told the GP she was concerned "someone has been messing with her". The child was referred to a paediatrician and on examination no evidence of abuse was found.

NOTE: This response was compliant with the procedure in place at the time and such cases were not referred to Children's Social Care unless concerns were confirmed. Current practice would involve a strategy discussion in any cases where the possibility of abuse was being considered. As there was no strategy meeting, any opportunity to share the wider background of concerns was lost. Mother's expressed concerns were not explored further in terms of who she thought might have abused the child. Neither the GP nor the paediatrician were aware of the concerns re sexual offenders in the extended family.

4.2. In 2006 there were concerns regarding sexualised behaviour involving older half-siblings 1 and 2 and children from a neighbouring family. During the investigation the girls reported being hit by Male 3, and school raised concerns about the behaviour of Male 3 towards them and the children's apparent fear of him with Children's Social Care and the police. Male 3 had been observed to exhibit very controlling behaviour.

4.3. During the investigation the mother and Male 3 were seen first and the children not interviewed for several days, potentially increasing the risk to them and giving ample opportunity for them to be coached in their responses. No Child Protection Conference took place. Responsibility for monitoring was left with school on a single agency basis.

NOTE: Practitioners reported a significant shift in culture in the intervening years and indicate they would request a Child Protection Conference took place and if still concerned would use policies now supporting agencies in escalating concerns in such circumstances. It was however suggested that these policies are better understood by some agencies than others.

4.4. In 2008 concerns re-emerged regarding the children being allowed to visit Male 7, a registered sex offender. Records evidence high levels of challenge to mother from the Health Visitor. Possibly as a result, mother requested a change of Health Visitor which was agreed.

4.5. When subsequently challenged by the social worker, mother and male 3 agreed to ensure no contact but in conversations with other professionals showed considerable ambivalence. Male 7 was subsequently found in the home alone with the children without any action being taken. Male 6, who was also a sexual offender, was also often present or found to be sitting outside the family home in his car.

4.6. In December 2009 the national Child Exploitation Online Protection Unit at the Home Office identified online chat-room conversations linked to a user of a phone in possession of the family. The content of messages included explicit details of sexual abuse of a child by her father. This was reported to the local police force but not actioned at the time due to an error.

NOTE: At this time two separate police computer systems were in place. The information was logged on one system but, due to human error, not the other so was not visible to staff who would have followed up and ensured a referral was sent to Children's Social Care resulting in a joint investigation. Now there is a single system which results in the need to take action being directly available to those who process these referrals.

4.7. The error outlined in 4.6 was identified five months later when a strategy meeting was convened in respect of new concerns about a potential physical assault on half-siblings 1 and 2 by Male 3, and there was a review of police records. Male 3 was cautioned for an assault on half-sibling 2. Allegations of physical abuse made by half-sibling 1 were considered to be inconsistent and were not progressed. An investigation commenced in response to the child exploitation online protection unit referral re the chat-room incident and computers and phones were seized.

NOTE: The implications of the content of the chat room conversations in terms of ongoing risks to the children at this point did not result in a specific risk assessment. This is a significant cause of concern and reflects a missed opportunity to better protect the children at that time.

4.8. Not until August 2010 was a Child Protection Conference held and a Child Protection Plan was put in place and this was in respect of continuing concerns re risk of sexual abuse from extended family members. The older children had been on holiday with Male 7 despite a requirement for no contact and mother had sought to cover this up with mis-leading information.

NOTE: An issue with the management of this case appears to be the tendency to focus on the issue of the moment rather than taking a wider view and keeping the range of concerns in focus. At this point there had still been no investigation of the chat-room concerns and the outcome of searches of the computer equipment seized in the previous December was not known.

4.9. In September 2011, some 21 months after the initial report from the child exploitation online protection unit referral re the chat-room content, the results of the forensic analysis of the phone and computer which had been seized were received and Male 3 was interviewed regarding the contents. The analysis had revealed several indecent images on his computer and the interview with him focussed on these. There were also numerous empty files with titles which suggested they had contained indecent material but the content

deleted. He admitted possession of indecent images and was cautioned for these offences. At this point he left the family home but continued to have contact with the children, supervised by church volunteers.

NOTE: There is no evidence that the material from the chat-room, which had prompted the investigation, was ever put to him despite the material relating to the description of the sexual abuse of a child by her father. This matter has been included in an internal review by Cheshire Police the outcome of which is considered later in this report.

4.10. In January 2012, after Male 3 had left the family home, a decision was recorded that the category of concern in the Child Protection Plan should be changed to Emotional Harm. Records indicate that a number of issues were identified as still needing to be addressed including the following:

- Assessment of male 3's contact with the children and its supervision;
- Direct work with the children re wishes and feeling;
- Work with the children re keeping safe; and
- Work with mother re risks posed by other convicted offenders.

None-the-less the Child Protection Plan continued under the category of risk of emotional harm.

NOTE: This is recorded as unanimous but practitioners recall not being happy about the change of category. Again, there was no escalation (there was no policy to support this at the time) and they describe deference to Children's Social Care as the norm at the time. The decision, as before, reflects a focus on the immediate i.e., as Male 3 was no longer in the home, it was considered that the risk of sexual abuse was reduced – there was no consideration of the ongoing risks from the wider family.

4.11. At the conference concern was expressed regarding the amount of time that the children had been subject to Child Protection Plans without there being any discernible or sustainable improvement in the parenting they had received, therefore it was recommended that the Local Authority seek advice of a Legal Gatekeeping Meeting[4] regarding any future plans, actions or assessments which needed to be undertaken to ensure the safeguarding of the five children.

4.12. The report presented to the Legal Gatekeeping Meeting majors on the fact that Male 3 is no longer living with the family and that contact is supervised.

[4] The Legal Gatekeeping Meeting was an arrangement internal to Children's Social Care whereby social workers sought legal advice when considering the possible need to take legal proceedings to protect children.

Although ongoing concerns re other family members is referred to, it is not seen as a significant factor and the outcome of the meeting was that the concerns were deemed not to be sufficient to initiate proceedings and it was noted that in some respects the children could be said to be better placed – i.e., attending school and appointments and clean and appropriately dressed.

NOTE: Staff in Children's Social Care report a significant change in practice in the intervening years. At the time Legal "advice" was taken to be a decision. This essentially undermined the social worker who had hoped to get support in initiating proceedings. The outcome of positive changes following the adverse Ofsted inspection is referenced in Ofsted's follow up report in November 2021. Internal audit in Children's Social Care also evidences practice changes in the recording of the rationale for decisions which is now a requirement and has been evidenced.

4.13. Five months later, in June 2012 the case was stepped down to a Child in Need case and then closed to Children's Social Care in the December. Agency records subsequently report that mother had a new partner Male 4 who had moved into the household. Records contain very little detail and a lack of clarity - even his name was unclear. His presence was picked up by school as a concern but the social worker declined to do police background check as the children were no longer on a Child Protection Plan and she felt she had no authority to do it.

NOTE: All incoming concerns are now managed via an "Integrated Front Door" which receives all work, not just Child Protection cases. Staff from a range of agencies sit together and work together as a team sharing multi-agency information to inform risk and an expression of concern such as this would now be subject to a routine police check.

4.14. Concerns were also being expressed about other men, and that the older children were in touch with potential offenders on-line and staying with them at times.

4.15. It is now known, but was not at the time, that in 2013 mother's then partner, Male 4, and mother herself committed serious sexual offences against Child I. This came to light due to the discovery of video images on Male 4's phone when he was arrested in April 2020 (seven years after the abuse had taken place). The video showed a child aged approximately four years old being sexually abused, now known to be Child I.

4.16. There has continued to be ongoing concern about the family in the intervening years. In February 2013 half-sibling 1 was observed to be distressed in school and stated "a bad thing happened last night". She was not prepared to give details. This was shared with the school nurse who spoke to mother about it but this was not taken further.

4.17. Around this time school picked up that Children H and I were having unsupervised contact with Male 3 and reported this to Children's Social Care. They were informed that the level of risk posed by him had been re-assessed and unsupervised contact could now be allowed. School was not happy and did raise concerns with this but did accept this as a matter for Children's Social Care. There was no formal escalation policy in place at the time.

4.18. In 2014 it was noted that another known sex offender, Male 5, was in contact with the family. A disclosure of his prior offences was made to mother as he was on the sex offenders register and Children's Social Care were notified but no further action taken.

NOTE: This potential further risk to the children did not prompt any enquiries nor any risk assessment.

4.19. During 2015 mother formed a relationship with Male 6. They were not living together but she was spending much of her time at his address where he cared for his son. This resulted in her neglecting the needs of her own children with the children H and I being left in the care of their older half-siblings. They describe being hungry and on one occasion locked out of the house at night and seeking help from a neighbour. An assessment was completed by Children's Social Care and a Child in Need Plan put in place to support the children's "emotional stability". At this time there were significant concerns about a relationship between half-sibling 3 (then aged 17) and an older man she was visiting in Manchester.

4.20. Records indicate that in March and June 2016 half-sibling 2 was noted to be at risk of sexual exploitation. A referral to the police noted that she was discussed in connection with Male 8, her uncle, and reference to him "providing alcohol, sending indecent images and inappropriate text messages". Male 8 was arrested and pleaded guilty to one offence of inciting a child to engage in sexual activity. A child protection conference was held and the children H and I and two of the older half-siblings were made subject of a child protection plan on the grounds of neglect.

4.21. Through the second half of 2016 numerous concerns were recorded. Mother's relationship with Male 6 had become volatile and mutually abusive. Mother alleged rape by Male 6, withdrew the allegation and then re-asserted her allegations and said he had threatened to hurt her if she did not withdraw. He alleged harassment and obtained a restraining order against mother. Mother breached the order resulting in a suspended prison sentence and the case was discussed in a Multi-agency Risk Assessment Conference[5] (MARAC). There

[5] MARAC: The Multi-Agency Risk Assessment Conference is a regular meeting where agencies discuss high risk domestic abuse cases, and together develop a safety plan for the victim and his or her children. Agencies taking part can include Police, Independent Domestic Violence Advisors (IDVAs), Children's Social Services, Health Visitors and GPs, amongst others.

was no ongoing contact with the National Probation Service due to the sentence having no management requirements on it.

4.22. During 2017 mother was noted to have been drinking to excess and taking medication for both depression and anxiety. In June 2017 Mother alleged rape by a man who came home with her from a party. Half-sibling 2 was distressed in school and recounted to staff how she had feared for her mother and had chased the alleged perpetrator down the street and kicked him. He had punched her in the face causing bruising and swelling to the mouth. School made a referral for appropriate support and gave details of support for mother. Police investigated the alleged assault alongside the alleged rape. This investigation exceeded the timescale for prosecution of a common assault so could not proceed to prosecution as part of the investigation, it is however unlikely to have proceeded in any event due lack of substantiating evidence.

4.23. Home conditions appear to have deteriorated during this period and the police officer, who had attended the premises in connection with the alleged rape, made a further referral to Children's Social Care reporting that the house was not fit for human habitation. The RSPCA were also involved during this period regarding animal welfare.

4.24. Following a review conference in November 2017 the children remained on a Child Protection Plan. It was known at this time that children H and I were staying overnight with Male 3 at times.

4.25. Around this time Child H developed epilepsy and school became heavily engaged in supporting her and her mother in managing this

4.26. In December 2017 the Child Protection Plan ceased and support was continued via the Common Assessment Framework[6].

4.27. During 2018 agency records reflect concerns about the half-siblings, now adults, re their relationships and pregnancies, growing concern for child I whose presentation was poor with signs of neglect, and whose behaviour in school was becoming increasingly difficult to manage and she was referred to the Attention Deficit Hyper-Activity Disorder /Autistic Spectrum Condition clinic.

4.28. In 2020 school raised concerns with mother re Child I's contacts with men via the internet and mother agreed to monitor her internet usage. In December 2020 signs of self-harm were noted in school and raised with mother who said she had removed all sharp instruments from the house.

[6] The common assessment framework (CAF) is a **process used to identify children's unmet needs** and support them.

4.29. Covid impacted significantly on agencies offering support to the family but there is evidence of high levels of support continuing via virtual contacts when school was closed and an Education and Health Care Plan (EHCP) was created to better support Child I.

4.30. In March 2021 police received information regarding the uploading indecent images of children involving Male 3. This did not prompt an immediate re-assessment of risk.

NOTE: For three months no additional steps were taken ensure the children were protected from potential risk of sexual abuse by Male 3..

4.31. In May 2021, West Mercia Police informed the Cheshire Police that, in the course of investigating offences involving indecent images, they had found video footage of rape and other sexual offences against a 4-year-old child, now identified as Child H. The alleged male perpetrator was one of mother's previous partners, Male 4. Both he and mother were directly involved in the abuse, were arrested and remanded in custody pending trial. A strategy discussion took place and Children H and I were placed in foster care and care proceedings commenced.

4.32. In June 2021 school were informed by Children's Social Care that Male 3's contact with the children was now to be supervised.

5. **Questions asked by the Panel -** In the Terms of reference for this review the Panel outlined a series of questions they wished to see answered - key lines of enquiry – and these are addressed in the following section of the report.

5.1. Question 1 - The context 2012/13 and what was known at the time:

5.1.1. Agencies had been working with this family for many years and the specific risk factors were well-known. Mother was known to have been abused herself by her father and other members of the extended family were also convicted sex offenders. Mother had demonstrated an inability to maintain a consistent position on the importance of keeping her children safe and had frequently either chosen not to, or had been unable to restrict contact.

5.1.2. It was known that mother's own relationships with men were often initially formed on-line and had involved a series of men who also posed risks to her and/or her children. Male 3 was cautioned for possession of indecent images of children. Another of her partners, Male 4 is the perpetrator of the offences which prompted this review. Little was known about him as background checks were not completed – however checks done at this time would not have exposed any concerns.

5.1.3. Chat-room discussion about abusing children had been identified suggesting ongoing risks.

5.1.4. Of possible relevance at this time was the situation in Children's Social Care which had, on inspection, been found to be inadequate. Inexperienced social workers were allocated this complex case and describe chaos both in family and department with many and frequent changes of supervisors.

5.2. **Question 2a - The system: how did the system respond to the available information in 2012/13, was it joined up, was it effective, did agencies understand their roles and expectations would the escalation process be used?**

5.2.1. The health visiting service and schools were pro-active in sharing information with Children's Social Care, and schools with police liaison officers. Agencies came together under arrangement for Child Protection and Children in Need but practitioners did not describe this as feeling like a team working to a single plan. They described a deference to Children's Social Care as the lead agency and the absence of an agreed assessment of risk. They described being concerned that the children were not being effectively protected but these concerns were not escalated – no escalation procedures were in place at the time.

5.2.2. School and health visiting staff shared information and all agencies engaged in the multi-agency planning processes but practitioners reported some reluctance to reciprocate on the part of Children's Social Care who did not share the notes of the Legal Gateway Meeting (on the grounds that this constituted legal advice) nor the risk assessment of Male 3.

5.2.3. Practitioners reflected a sense of helplessness in delivering an effective plan. Mother's failure to ensure safe arrangements for her children was evident, with potential abusers still in contact with them, but there were no consequences and this issue was treated as if it were a matter of advice not a requirement.

5.2.4. At a review conference in 2012 there was outstanding work in relation to direct work regarding the children's wishes and feelings and also work with them in terms of keeping themselves safe. Also, there was work yet to be completed with mother to improve her understanding of the risks that adults may pose. By this time Male 3 had left the family and it was agreed he needed to continue to reside away from the family home and both parents were confirming that their relationship had now ended.

5.2.5. A decision was made to change the category of concern to emotional abuse at this point – it is difficult to understand the change of category of risk as risk of sexual abuse had been of major concern throughout and remained so and the work on protection had not been completed.

5.2.6. The way the case was managed must have given very mixed messages to the children and family – e.g., social worker sought advice from Legal Panel re possibility of Care Proceedings but grounds not judged to be met and, despite this high level of concern, the case was stepped down and closed within months; sex offenders from the extended family continued to have contact with the children with no consequences.

5.2.7. There were missed opportunities to work more directly with the children and only on one occasion was action taken to directly challenge the men themselves. Generally, no thought seems to have been given to legal remedies which might have been followed up with enforcement if breached

5.2.8. The police response to the child exploitation online protection unit referral referral in respect of the chat-room activity was inadequate. It was not actioned at the time and therefore was unknown to key agencies working with the family for several months. When this was recognised some five months later, there were further delays and the focus shifted to on-line images which had been found on Male 3's phone. The chat-room concerns were never fully investigated.

5.3. Question 2b - The system: How would the system respond to the information in 2021 – Do agencies understand their roles and expectations, would the escalation process be use?

5.3.1. Practitioners report now feeling like being part of a team when working on Child Protection or Child in Need cases. They are now aware of escalation procedures and could give examples of their use. They were not, however, confident that there was a sufficiently widespread understanding among agencies who did not routinely get involved in this work.

5.3.2. Practitioners described different processes for the stepping down of cases being in place now, with much greater multi-agency involvement and specific follow up plans being put in place. They described mechanisms for challenge and a greater confidence in the effectiveness of joint working.

5.3.3. Cheshire Police have conducted a thorough review of practice and the issues highlighted in this review. There is evidence of change for the better and many systems have been updated and improved over the years. Significant progress has been made in respect of analysis of material held on phones. The changes already implemented have resulted in the backlogs for mobile phone examinations reducing from 26 weeks to 2 weeks. All victim and witness devices are turned around within 24 hours. In January 2022 the team received 27 victim/witness devices and all were completed and returned within the set 24-hour timeframe. Computer backlogs have reduced from two and a half years and at the time of writing sit at 7 months and are expected to continue to reduce.

5.3.4. The recording of child exploitation online protection unit referral referrals on duplicate systems no longer exists and there are systems in place to ensure proper process is followed and outcomes are recorded.

5.3.5. In the years running up to 2013 numerous concerns about contact with sexual offenders were dealt with via advice to mother within the framework of a Child Protection Plan, advice which was not acted upon with no consequences. The risk assessments around these offenders were either not in evidence or not robust and professional concern focussed very narrowly on this household despite there being an extensive family network within which these offenders accessed numerous other children.

5.3.6. The Partnership audited two current cases involving intra-familial and multi-generational abuse. Examination of the cases evidenced an awareness of the need for detailed risk assessments to be completed and in both cases, there was a multi-agency approach to risk management. In one case a detailed assessment had been competed using the "Persons who pose a risk to children" tools and consideration of risk to other children had been included. In the second case an AIM assessment[7] had been completed previously but did not directly inform the assessment of risk and was not linked until later. One case evidenced good work across most fields of enquiry.

However, a number of issues emerged and actions have been agreed in response:

- Professional challenge was still lacking with some decisions still being seen as single agency when they needed multi-agency input;
- Strategy meetings were not held at the earliest opportunity and need to be more-timely. The delay could have impacted on the safety of the child and siblings.
- Staff engaged in ABE[8] process need to be appropriately trained.
- Assessments were not always of good quality nor always timely.

5.3.7. Taken as a whole the outcome of the audits suggests there is further work to do.

5.3.8. Children's Social Care have carried out a review of work across the extended family of Child H and I in parallel with this review and can evidence that risk assessments have been completed as appropriate. Further work is

[7] The purpose of the AIM assessment is to offer an assessment of the young person and his or her family to assess the concerns, risks and strengths of the young person across four key domains; sexual and non-sexual behaviours, development, family and environment considering both static and dynamic factors.
[8] Guidance for investigating officers and others involved in interviewing vulnerable witness is set out in 'Achieving Best Evidence (ABE) in Criminal Proceedings".

being undertaken to support the local school who work with a number of families identified as vulnerable in terms of potential sexual abuse.

5.4. **What can we learn from the daily lived experience/perceptions and behaviours of these children that would help us to respond to known and perceived risks in the future?**

5.4.1. It has not been possible to date to speak directly with the Children H and I or other family members about their lived experience due to ongoing criminal investigations but much can be inferred from the chronology. Children I and H were born into a family where there had been issues about the care and protection of children for many years.

5.4.2. The older girls talked relatively freely about home when at school and were often distressed; School engaged with them in sessions focussing on their wishes and feelings but this did not appear to greatly influence plans. There was violence from Male 3 towards them and violence between them; half-sibling 3, in particular, was able to voice her distress very clearly.

5.4.3. Their experiences, distress, and the concerns it exposed, paint a picture of a household where relationships often erupted into violence, where mother had poor parenting skills, where in later years neglect of the children's physical needs became more of an issue. The lengthy chronology of concerns appears to have been treated as single issues and dealt with as such but the whole picture not brought together resulting in lengthy periods of intervention with little sustained improvement in their lived experiences.

5.4.4. At the conference in January 2012 a unanimous decision was made that all but the eldest half-sibling (now approaching adulthood) should remain subject to a Child Protection Plan under the category of Emotional Harm. A Legal Gatekeeping Meeting regarding any future plans, actions or assessments which needed to be undertaken to ensure the safeguarding of the five children was also held. The wishes and feelings of the children do not appear to have been sought or reflected in these processes.

5.4.5. The way the case was managed must have given very mixed messages to the children and family – e.g., social worker sought advice from Legal Gatekeeping Meeting re possibility of PLO/Care proceedings but grounds were not judged to be met and despite high levels of concern the case was stepped down and closed within months.

5.4.6. The older girls' behaviour suggested a high risk of child sexual exploitation.

5.5 **To what extent has the current Covid-19 crisis impacted either on the circumstances of the child or family or on the capacity of the services to respond to their needs?**

5.5.1 The most significant impact was on the children's face to face contacts and attendance at school. There were, however, high levels of virtual contact.

6. Analysis:

6.1. While multi-agency arrangements in respect of children in need and child protection plans were in place the processes were flawed. Plans were not based on focussed assessments and did not bring about improvement. Agencies did not have a consensus as to the level of risk but deference was given to the view of Children's Social Care as the lead agency with no escalation. Lengthy periods of statutory involvement produced no change.

6.2. No assessment of mother's capacity to protect her children was undertaken and the plans which relied upon her to keep the children safe were unrealistic. Repeated examples of her inability to ensure no contact between her children and known sexual offenders were tolerated without consequences.

6.3. Schools were appropriately professionally curious about home life and mother's partners but the concerns which arose in respect of incidents involving children from other households, including children in the wider family network and the potential that the risk of sexual abuse extended beyond this specific household were not always appropriately followed up by other agencies.

6.4. Practice was largely reactive and practitioners talked about "chaos" within the family and the struggle to respond to the level of demand. During the period around the time of the offences which prompted the review (2012/13) Children's Social Care was found to be inadequate on inspection. The social worker at that time was inexperienced and had frequent changes of supervisor – five in a 12-month period.

6.5. When mother voiced concerns re possible sexual abuse the GP made a referral to a paediatrician. This was in line with procedures at the time and, in line with these procedures, mother's concerns were not investigated as a child protection issue and neither GP nor the paediatrician knew of the concerns about potential sex offenders in the family and in contact with the children. Had this been responded to as a child protection concern and a strategy meeting held then this information would have been shared. Why mother thought the child might have been abused would also have been explored.

6.6. The management by police of the concerns about texts in the chat-room is a significant concern. A human error resulted in no information being shared and no investigation being commenced for over five months despite the

circumstances suggesting a child might be actively being abused by their father. When the error was discovered and computers etc. seized, there was further delay. The investigation side-tracked to a focus on indecent images held on the computer and the chat-room incident was never investigated.

6.7. It took some time in the process of investigation of the videos of abuse in West Mercia to identify the mother and the likely victim. However once identified mother was arrested promptly and appropriate action taken.

7. Recommendations

7.1. Context:

7.1.1. There have been very many changes in professional practice in all agencies over the course of time considered in this review. Most significantly in the period 2012-13 children's social care was judged to be inadequate in a service inspection and the social worker managing the case described "chaos in the family and chaos in the department". She had numerous changes of manager and inconsistent supervision. At the time of the most recent service inspection in 2019 Ofsted found the service no longer inadequate but still requiring improvement to be good. A monitoring visit in November 2021 showed positive practice in many areas but also areas still requiring attention.

7.1.2. Specifically, the letter following the monitoring visit comments on number of areas of work which are relevant to this review:

" *Children in Cheshire East benefit from stable and meaningful relationships with their social workers. Children have frequent opportunities to express their wishes and feelings, and social workers complete purposeful and creative direct work with children to better understand their experiences. While children's wishes are considered in plans, written records are not always clear about whether children have the opportunity to be actively involved in meetings about them.*

Timely assessments of children's needs include careful consideration of family history and children's experiences to appropriately identify strengths and risks for children. The views and opinions of children, parents and relevant professionals are sought effectively to inform assessment conclusions. Children who need help or protection are identified as a result of effective assessments of risk and need.

Thresholds for working with children are appropriately applied. However, some assessments do not fully consider children's identities when reaching decisions, and assessments are not always updated promptly when

children's circumstances change. For a small number of children, this has resulted in a delay in identifying and responding to their changing needs.

Most children in need of help or protection have written plans that are regularly reviewed and updated. Most written plans are clear about what needs to happen and who is responsible. While social workers can verbally describe the positive impact their work is intended to have on children's daily lives, some written plans still measure success by the completion of tasks rather than impact for children. Contingency arrangements in child-in-need plans are not always sufficiently well-formed or detailed.

Management oversight is also not always fully responsive to children's changing needs, and child-in-need meetings do not always lead to the identification of drift for children. This all means that, when situations deteriorate for children in need, alternative decisive action is not always taken promptly."

7.1.3 Children's social care have developed an action plan in response to the findings from the Ofsted visit and so specific recommendations are not made in this review where the required action is already incorporated in this action plan.

Recommendation 1: CESCP should continue to receive updates from the Director of Children's Social Care regarding the completion and effective implementation of the action plans made in response to Ofsted inspection activity.

7.2 **Lack of focus**

7.2.1 In the early 2000s this family comprised a mother with changing male partners, three teenage children and two very young children. There were concerns about risks from known sex offenders in the family network and the family was a cause of concern to agencies over numerous years with periods when the children were subject to child protection plans or supported via early help arrangements with school acting as lead agency. Risks of sexual abuse were the predominant concerns but mother's parenting skills and the degree of neglect the children experienced were also issues.

7.2.2 During periods when formal Child Protection plans were in place written plans did set out actions/requirements but these were not always fulfilled and non-compliance from mother and her partner did not lead to review of plans. Social work responses were reactive to the presenting problems and did not address wider issues, for example clearly inappropriate exposure of the children to known sex offenders in the family did not always prompt concern for other children in the wider family network.

7.2.3 The social worker in the critical 2012-13 period was inexperienced and lacked effective supervision. Assessments were not holistic and did not

recognise or draw on the children's lived experience. Improved supervision and management oversight can now be evidenced via audits.

7.2.4 The recent Ofsted visit presents evidence of change –they describe children who need help and protection being appropriately identified; assessments are described as timely and inclusive of the views and opinions of young people; they are described as being based on careful consideration of family history and informed by other relevant professionals; practitioners are found to be doing creative direct work with children.

7.2.5 In view of this evidence of improved practice no specific recommendations are made in respect of generic assessments and the voice of the child in assessment and planning. (See Recommendation 1)

7.3 **Escalation**

7.3.1 On numerous occasions agencies were concerned about decisions made by Children's Social Care and did voice concerns but not escalate them when this produced no change. At the time there was no multi-agency escalation policy in place

7.3.2 Appropriate policies are now in place both for escalation of concerns and for challenge to outcome of a case conference. Practitioners who participated in the learning event said they were confident in using them and reported examples of effective use. However, they also felt more needed to be done to ensure wider awareness and increase confidence in professionals who may be less experienced in safeguarding work and that application is still variable. A review of the arrangements is overdue and, although use is monitored, this is not reported via any quality assurance reporting.

Recommendation 2: CESCP should ensure the planned review of the escalation policy is completed.

Recommendation 3: CESCP to require the escalation tracker to feed into the Learning and Improvement Group on a quarterly basis.

Recommendation 4: CESCP should use the publication of this review to increase awareness and confidence in using the Escalation Policy and monitor its effectiveness.

7.4 Inter-generational abuse

7.4.1 There is a considerable body of research into inter-generational abuse and the impact on a mother of abuse in their early life and likely impact on their later life and parenting. In this case the mother's own history of abuse was known to agencies but no assessment was done as to how this had impacted on her parenting, her relationships, and particularly her capacity to protect her children.

Recommendation 5: CESCP should ensure practitioners have access to training in respect of the impact of inter-generational abuse and tools to support risk assessments.

7.5 **Management of sex offenders and risk assessments**

7.5.1 Only in respect of Male 3 was any risk assessment carried out and this was in response to indecent images being found on his phone. Assessment of sex offenders is a skilled activity. This assessment of Male 3 was completed by the social worker for the case who had not had any specialist training. The risks posed by other members of the family and mother's various partners were not assessed as part of the child protection planning, though those family members who were registered sex offenders were monitored as required by the police. Only on one other occasion was action taken to address issues relating to this family directly with a male who posed a risk - this was Male 8 who was arrested and charged with inciting a child to engage in sexual behaviour.

7.5.2Though assurance has been given re the current position, the risks to other children in the wider family network do not appear to have always been considered or investigated on a timely basis. This suggests a gap in the professional understanding of sexual offender behaviours and the need for risk management.

Recommendation 6: CESCP should ensure that, where convicted sex offenders are in contact with children appropriate and effective risk management mechanisms are in place.

Recommendation 7: CESCP should consider with partners the arrangement for risk assessments and safety planning where the allegation is regarding an alleged offender rather than one with convictions.

Recommendation 8: Agencies should work together to ensure that potential risk from sex offenders in the family network are assessed in respect of other children with whom they have contact.

7.6 Voice of child

7.6.1 The older children in the family frequently expressed their distress in school – this was recorded and shared with children's social care. They described fear, physical abuse, emotional abuse and neglect. On some occasions, e.g. allegations of physical abuse by Male 3, an investigation was commenced but this did not generally prompt a wider assessment and insufficient importance was placed on the voice of the child.

7.6.2 Practitioners identified a significant shift in culture in the intervening years (also see recommendation re escalation processes) They described a multi-agency approach to protecting children which results in agency concerns being acknowledged and assessed. They described the voice of the child and their lived experience being central to assessment and planning and this is supported by the evidence from the recent Ofsted monitoring visit.

7.6.3 In view of the evidence of change no recommendation is made.

7.7 Timeliness of forensic testing where children are at risk of abuse

7.7.1 There were very significant delays in the processing of forensic evidence from phones and computers in both the investigations in West-Mercia and in Cheshire. This review has been provided with detailed evidence of change in Cheshire in respect of forensic analysis of phones. A report has also been received from West Mercia Police providing assurance but lacking the supporting evidence of improvement.

7.7.2 When agencies became aware of the allegations re concerning online activity, they awaited the outcome of forensic investigations without any more immediate local risk assessment. This potentially left risks to the children un-assessed and unmanaged.

7.7.3 Computer analysis remains a significant concern. This appears to have been a direct result of lack of resources.

Recommendation 9: CESCP should share the concerns re forensic analysis in cases involving risks to children with the relevant safeguarding partnership in West Mercia and recommending they seek further assurance and evidence of improvement

Recommendation 10: CESP should ensure policies and procedures re-enforce the importance of specific risk assessments, such as the "Persons who Pose a Risk of Harm" tool, being completed pending the outcome of forensics, and that protection from potential risk on a timely basis.

8. Good practice

8.1 The schools who were involved with this family showed real strength in capturing the lived experiences of the children and recording their voices. They showed considerable persistence in exposing their concerns and provided a safe space for the children. There are many examples of practical support to the children and to their mother.

8.2 The chronology prepared by education was particularly thorough – this was possible due to the level of detail held in their school records.

8.3 The tenacity of the health visitor in raising her concerns about potential risks from sex offenders in the extended family is to be commended.

8.4 The internal review completed by the Cheshire Police during the course of this review is of high quality, is detailed and will form the basis of further action to continue the improvements which have a been evidenced.

Appendix 1 – Terms of reference

CHESHIRE EAST LOCAL SAFEGUARDING PRACTICE REVIEW

This document contains the Terms of Reference, research questions (KLOEs) and outline timetable for the review.

Each of these will be reviewed throughout the process to ensure that they are meaningful and relevant.

Key contacts for the review are Alistair Jordan Business Manager Cheshire East SCP and Jane Booth, Independent Chair.

1. TERMS OF REFERENCE

Operation and Governance

1. All relevant agencies in Cheshire East will be included in the review.
2. The review will be overseen by a panel of senior representatives from relevant agencies. Panel members will be responsible for ensuring their agencies fully participate in the review and for working with the author to produce a final report.
3. The review panel will agree a communications strategy
4. Administrative arrangements will be agreed and provided by the SCP Partnership Business Team.

Methodology

5. The review will use blended methodologies which will involve desktop data gathering, interaction with professionals and individual accounts to inform its conclusions and recommendations
6. As appropriate the review will refer to national guidance, policy, practice and other reviews to inform its conclusions and recommendations
7. The review will make every effort to involve the subjects of the review as appropriate. The review will also give consideration to involving the families and significant others. This will be decided by the panel as the review unfolds.
8. The event itself is considered to be the catalyst for the review and will not be analysed in detail, this is the job of the criminal investigation which is ongoing.

Scope and Outcomes

9. The review will focus on the Key Practice episodes of

a. From 2006 concerns regarding inappropriate/sexualised behaviour involving older half siblings, the behaviour of their stepfather towards them and the children’s apparent fear of him.

b. 2008 concerns regarding the children being allowed to visit their grandfather, a registered sex offender.

c. December 2009 Cheshire Police received information from CEOP, regarding a mobile phone, which was linked to the mother and father, having been used in chat logs concerning child sexual abuse.

d. Discovery of video images on a phone of a male arrested in April 2020, of a child aged 4 years being sexually abused dated to 2013 with the mother present.

10. The review will aim to complete by January 2022 however it is recognised that criminal proceedings and other factors may affect the timescale for completion

2. KEY LINES OF ENQUIRY

Question 1: The context: What is known about the key practice episodes:

- specific risk factors (individual and collective)
- effectiveness of responses i.e., actions being followed up

Question 2a: The system: How did the system respond to the available information at the time of the key practice episodes? Was it joined up? Was it effective? Did agencies understand their roles and expectations? Was the escalation process used?

Question 2b: The system: How would the system respond to the information in 2021? Would it be joined up? Do agencies understand their roles and expectations? Would the escalation process be used?

- The use and quality of tools, single and multi-agency, to assess and inform risk assessment and the effectiveness of these in informing risk management plans
- Information sharing by professionals.

Question 3: The people: What can we learn from the daily lived experience/perceptions and behaviours of these children that would help us to respond to known and perceived risks in future?

The National Child Safeguarding Practice Review Panel have specifically requested that this question is included in the review.

Question 4: to what extent has the current Covid-19 crisis impacted either on the circumstances of the child or family or on the capacity of the services to respond to their needs?

Outcomes: Establish if the practice evident at the times of the key practice episodes remain pertinent in 2021 and if so, make recommendations for practice improvement.

3. DRAFT TIMETABLE

Date	Actions
First Panel Meeting 22/9/21 Stage 1: Methodology and Information Gathering	• Agree timetable, TORs, KLOEs and time period • Discuss the background to the case • Agree agency information formats (desktop review, specific enquiries) • Discuss family involvement • Discuss criminal proceedings • Discuss other relevant issues
Independent chair review	Desk top review Practitioner interviews/workshop
2nd Panel Meeting Stage 2: Analysis	Review information Identify early findings and discuss format of final report/conclusions and recommendations Review involvement of subjects/families
Final Panel Meeting	Independent Chair to present draft report

Stage 3: Findings/Final Report	Discussion re findings/conclusions and recommendations Finalise involvement of subjects/families
Sign off Meeting	Sign Off final report