
Wiltshire Safeguarding Children Board

# Report of the Serious Case Review regarding 5 Siblings (Family M)

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# 1 Introduction

## Why this case is being reviewed

1.1 This serious case review was commissioned by Wiltshire LSCB (WSCB) because of concerns regarding five children and a young unrelated adult who was living in the family home. In September 2014 evidence became available that the Father of the two younger children (Mr W) was found to have watched Category A, Category B and Category C[1] child abuse images online and uploaded them onto shared sites so others could watch them. At this time, the identity of the children in the images was not known, but it was known they were of pre-pubescent boys aged between 10 and 12 years old and some girls who appeared to be around the age of 10. In February 2016, it was found that one of the children, living in the family home, had been sexually abused by Mr W who then pleaded guilty to 43 child sex offences and received a custodial sentence of 18 years.

1.2 Serious Case Reviews play an important part in the broader efforts of the LSCB to achieve a safer child protection system and ensure all children and young people are effectively safeguarded. Consequently, it is important to consider what happened and try and discover why in a particular case; but then to go further and reflect on what this might reveal about underlying gaps and strengths in the child welfare system that may reappear in other cases. In this case the purpose is to reflect on the service response to the children and their parents.

## Summary of the case

1.3 This review focuses on five children Sibling 1 aged 4, Sibling 2 aged 6, Sibling 3 aged 8, Sibling 4 aged 10 and Sibling 5 aged 12 (all ages at the start of the review period). They were all living with their Mother and Mr W. There are also two older siblings (14 and 15) who lived away from home with their Father and had no contact with professionals during the period under review. All the children have the same Mother; the two youngest children's Father is Mr W. Sibling 3, 4 and 5 all have different Father's. A young person called YP1 (aged 17) also lived in the family home. The family are white/British.

[1] Images that involve penetrative sexual activity with a child are classed as category A images. Images that involve non-penetrative sexual activity are classed as category B images. Other child sexual abuse images not falling within categories A or B fall into category C. DA distinction is also drawn regarding possession, distribution and production and this influences the assessment of the severity of the criminal activity and likely sentencing.
Sentencing Council (2013) Sexual Offences Definitive Guidelines; page 76 https:// www.sentencingcouncil.org.uk/wp-content/uploads/Final_Sexual_Offences_Definitive_Guideline_content_web1.pdf

1.4 There had been historic concerns from schools and the police regarding the neglect and potential emotional abuse of the children starting from 2007, when Sibling 3 was 9 months old, Sibling 4 aged 2 and a half and Sibling 5 aged nearly 5. In addition, there were some concerns regarding Mr W being domestically abusive to Mother and both Mr W and Mother being physically abusive to the children. Over time assessments were completed by Children's Social Care and these culminated either in a conclusion that the concerns had not been substantiated or, in the later years, that further assessment was needed, but which did not happen. In 2013 Early Help Common Assessment Framework (CAF[2]) plans were opened on the children, but Mother and Mr W did not attend meetings and these were discontinued.

1.5 In September 2014 Mr W was found to have downloaded video images of children being sexually abused and shared these images with others in chat rooms. Mr W admitted the downloading offences, was arrested and released on bail conditions not to have unsupervised contact with any child. He moved to live with a relative. Mother was made aware of the seriousness of the concerns and asked by Children's Social Care to sign an agreement not to allow Mr W to have any unsupervised contact with the children, which she agreed to do.

1.6 Joint Police and Children's Social Care (CSC) Child Protection inquiries[3] were planned and Criminal inquires started. The criminal investigations were delayed because of the volume of ongoing serious police investigations regarding adults involved in sexual abuse. There was a further assessment by CSC and an Initial Child Protection Conference (ICPC)[4] was planned but cancelled after an assessment had been completed, and the children were made subject to Child in Need (CIN) Plans[5]. The CIN process continued for 14months. There were initially a number of changes of social worker but for 10 months there was a consistent group of professionals. During this time, there were concerns held by schools regarding neglect and the children's emotional wellbeing, which were unaddressed.

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[2] The Common Assessment Framework (CAF) is a process for gathering and recording information about a child for whom a practitioner has concerns in a standard format, identifying the needs of the child and how the needs can be met.

[3] Children's Services have a legal duty to look into a child's situation if they have information that a child may be at risk of significant harm. This is called a child protection enquiry or investigation. Sometimes it is called a "Section 47 investigation" after the section of the Children Act 1989 which sets out this duty. The purpose of the enquires is to gather information about the child and their family so that social workers can decide what action, if any, they need to take to keep a child safe and promote their welfare.

[4] An Initial Child Protection Case Conference is a multi-agency meeting often attended by family members which takes place within 15 days of the strategy discussion/meeting if as a result of the child protection enquiries a child or young person is considered to be at risk of significant harm . Those at the meeting (conference) discuss the risk to the child and decide what needs to happen to make sure they are kept safe.

[5] A child in need plan should be clear about what the assessment (Initial or Core) has identified as needing addressing, which agencies will provide services and what is expected of the parents/caregivers and the child or young person. http://www.legislation.gov.uk/ukpga/1989/41/section/17

1.7 Mother separated from Mr W in 2015, started a new relationship and was pregnant in August 2015. There were some concerns that emerged regarding this new partner, which were considered, but not fully assessed.

1.8 The CIN plans were ceased in October/November 2015 but there were growing concerns regarding Sibling 5 and her Mother's negative and emotionally abusive behaviour towards her in the period November 2015 to January 2016.

1.9 Mr W's bail conditions remained in place until February 2016. There were anonymous allegations that he was seen at the family home, but there were unannounced social work visits and surveillance by the community policing team and these allegations were never substantiated. In February 2016 it was established, through forensic examination, that the sexual abuse images provided evidence that one of the children had been subject to sexual abuse by Mr W and he was convicted of a number of child sex offences.

1.10 The children were made subject to child protection plans. Sibling 4 had already moved to live with his Father (in September 2014) and Sibling 5 moved to stay with her Father. Care proceedings were sought regarding those children remaining at home. YP1 moved to independent accommodation.

## Summary of the Review Methodology

1.11 The expectations of a Serious Case Review as contained in Working Together 2015[i] is that they are conducted using a systems approach, but no specific methodology is prescribed. This review has been undertaken using the Learning Together systems model developed by the Social Care Institute for Excellence and more details about this can be found at http://www.scie.org.uk/publications/guides/guide24/index.asp. SCIE provided quality assurance supervision at key points in the data analysis process and at the end when the final report was in draft form.

1.12 Information is provided in Appendix 4.1 about the methodology, the author and the process of this review.

1.13 The review was also assisted by a case group of frontline professionals across all the relevant agencies, who either had direct involvement with the children, Mother, Mr W and the extended family or were managing and supervising the professionals. They provided data and sensitive critical reflections to help to understand the professional response at the time. This has not been an easy thing to do and the Independent Reviewer is genuinely grateful to them for their honesty and openness.

1.14 Interviews were held with all professionals and a substantial quantity of case records from across the agencies was accessed and reviewed. This data was analysed by the Review Team and formed the basis of this report. The Case Group were involved in subsequent discussions about emerging findings.

## Family Involvement

1.15 Family members and YP1 were offered the opportunity to meet with the reviewer and share their views, but these offers were declined.

## The Lead Reviewer

1.16 The Lead Reviewer, Jane Wiffin is accredited in systems learning and the SCIE "Learning Together" model and is an experienced independent investigator and safeguarding lead who has undertaken many Serious Case Reviews nationally over the last 15 years. Jane has a professional background in social work, training and policy development. She has never worked for any agency in Wiltshire and is completely independent. It was originally intended that the Review would be undertaken with a trainee reviewer from a local safeguarding agency. This joint process was started but the second reviewer had to withdraw from the process three months into the review.

# 2 Appraisal of Professional Practice in this case

2.1 This section provides a summary chronology and appraisal of practice. This sets out the view of the Review Team and Case Group about how effective the professional response was to this family, in the time under review. Where possible, it provides explanations for the practice seen and indicates where these issues will be discussed more fully in the detailed findings. Section 3 then discusses in detail the priority findings that have emerged from this Serious Case Review.

## Appraisal of Practice

2.2 The professional response to the children and family in this case was influenced by a number of issues. First, the very serious and growing issue of adult men who view and share child abuse images. This is a rapidly growing area of concern for all child protection agencies, and it is an area where knowledge of best professional practice lags behind the growth in harmful activity. There is national debate about judging both the seriousness of these offences, and the likelihood of viewing child abuse images- often referred to as "non-contact sexual abuse" - turning into the contact sexual abuse of children. These are complex matters and matters that faced professionals throughout this review. This review starts with the belief that viewing child abuse images is not a passive activity and that behind every child sex abuse image abuse has occurred. Children are the victims of sexual abuse when the images are produced, and they remain victims every time the images are viewed; the knowledge for some that these images can be repeatedly seen by many people causes on going trauma. Watching others sexually abuse children is child abuse.

2.3 The second major issue here is that of long term neglect and how this serious challenge to children's wellbeing is recognised, communicated, analysed and addressed by the multi-agency group.

2.4 The third issue is the complexity of working with blended families where there are different parent figures and where children live with different members of the family. In this case there were 8 children in the family with 4 different fathers. There was also a young person aged 17 who was not related to the family, but he had moved to stay in the family home. Two of the children were non-resident, living with their Father, but little was known about them other than that they had some contact with their siblings. Making sense of the family circumstances was made more complex both by the number of people involved and uncertainty about who should and could be invited to meetings, who did and did not have parental responsibility, or who should and should not be involved with assessments.

2.5 The final compounding issue was the workload and staffing difficulties experienced by some agencies during the period of time under review. The social work team in one of the locality

areas in Wiltshire had simultaneously experienced an increase in referrals, high turnover of staff and the use of agency staff to fill vacant posts. This had an impact on their response to this case. There were six different social workers responsible for the children and the family from the contact in September 2014 to December 2014; as Children's Services were the Lead Agency this impacted significantly in taking forward the child in need processes and the need for further risk assessments. These issues have subsequently been addressed.

2.6 The school nursing service also experienced high staff turnover and this meant that there were a number of different school nurses involved in the CIN process and the health aspects of the CIN plan were either delayed or not completed. This too has been addressed.

2.7 The Police Child Internet Exploitation Team were undertaking a large number of sexual abuse investigations (94 in total) of a serious and complex nature at this time. The unexpected increase in the volume of work resulted in a waiting list for the forensic examination of the electronic devices seized at the time of the arrest of Mr W, with a consequent 17 months delay in being able to know if any of the images downloaded by Mr W were of the children in the household and therefore whether there was evidence of contact sexual abuse. The waiting list has been reduced considerably.

## September 2014: Information received regarding child sexual abuse images being downloaded and shared

2.8 At the beginning of September 2014 Wiltshire Police and Wiltshire Children's Social Care (CSC) received full information regarding the uploading of sexually abusive images of children traced to the home address of Mother and Mr W. A comprehensive Strategy Meeting[6] was convened. Information was shared about historic concerns, current worries held by the schools about neglect of the children and the nature of the online images. It was known that the images viewed were of pre-pubescent boys aged between 10 and 12 years old and some of girls who appear to be around the age of 10; there were 14 category A videos[7]; 2 category B videos[8]; and 27 category C images[9]. The conclusion was that there was a significant risk of sexual abuse and possible neglect of the children. It was agreed that a joint police and Children's Social Care (CSC) child protection inquiry would be undertaken and an Initial Child Protection Conference was planned. This was a clear and appropriate focus and plan of action, which later became diluted over time.

[6] A Strategy Meeting (sometimes referred to as a Strategy Discussion) is normally held when there is an indication that a child has suffered or is likely to suffer Significant Harm. The purpose of a Strategy Meeting is to determine whether there are grounds for a Section 47 Child Protection Enquiry

[7] video images of sexual acts with children included penetration

[8] video images involving children in non –penetrative sexual activity

[9] video images involving children in non –penetrative sexual activity

## Initial Joint Investigation undertaken by the Police and CSC

2.9 The next morning a Police Officer (PO1) and a Social Worker (SW1) visited the family home. Mr W admitted to downloading the images but denied having a sexual interest in children. He was arrested, released on conditional police bail whereby he would have no unsupervised contact with any child under the age of 16. He agreed to go to his Father's home (PGF1).

2.10 As part of this initial visit Mother was made aware of the seriousness of the offences and the nature of the images found. She was asked to sign a written agreement by SW1 to confirm that Mr W would have no unsupervised contact with the children and supervised contact was organised and managed for the next nine months by CSC. Mother did not take the written agreement seriously[10], and there were occasions immediately after Mr W was arrested when she sought clarification of its meaning, and challenged why Mr W could not be in the family home. These issues were raised as a concern by PO1 but the ability of Mother to protect the children was not assessed and an understanding of the importance of this, in the context of an understanding of sexual offending and the risks to children, is discussed further in Finding 1. The dependence (in part) on the written agreement as a way of ensuring safety for the children, in the absence of a clear assessment of Mother's ability to protect the children, was overly optimistic.

## Children Interviewed

2.11 All the children were interviewed by SW1 and PO1. It was a joint agency decision not to undertake the interview under the auspices of the Achieving Best Evidence Framework (ABE[11]) because this could be traumatising for the children – with the plan that this ABE Framework would be used if evidence of abuse emerged; this is a routine approach to potential disclosures of abuse.

2.12 The four oldest children were interviewed at school and Sibling 1 at home. The written record of these interviews is very limited, and it is therefore unclear what the children were asked and to what extent concerns, regarding sexual abuse, were explicitly explored. The records suggest there was a more general focus on family life and family relationships. It was not acknowledged that the two younger children did not have the necessary language skills to share any harmful experiences verbally, and there should have been communication

[10] Written Agreements are no longer used in Wiltshire and therefore there are no Findings regarding them in this report

11 Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures is Government guidance which describes good practice in relation to the interviewing of and giving of evidence by vulnerable witnesses (children and vulnerable adult witnesses). https://www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf

with the school staff, who knew their communication style well, about how best to undertake the interviews. The issue of appropriate and sensitive interviews with children in the context of possible abuse is addressed in Finding 2. The schools also felt that the arrival of the police and social worker was scary for the children and that this may have unintentionally had an impact on them and their ability to share any concerns. However, this issue was never discussed or addressed and the ability, and confidence, of the multi-agency group to challenge the analysis and decision making of the lead agencies is discussed in Finding 3.

2.13 Once the initial child protection inquiries had been undertaken the Police and CSC investigations became separate processes and there was a lack of meaningful coordination or discussion between these pivotal agencies from this point onwards. This meant that the expertise of the Police Child Internet Exploitation Team was not utilised and did not inform either the CSC assessment or the subsequent CIN processes. This is discussed further in Finding 1.

2.14 The police ensured that data held in America was preserved and Mr W's electronic equipment was submitted for forensic examination; because of the volume of child abuse investigations the request was placed on a waiting list at number 77. The police carried out a risk assessment which concluded that because Mr W was bailed to live away from home; to not have contact with any children; a written agreement was in place; and that there was to be a multi-agency child protection conference and plan, that protective measures were in place. This risk assessment was not revisited when the decision was made to hold the case at CIN level and at this point there should have been liaison between the Police Child Internet Exploitation Team and CSC to consider what further protective action should be taken. The delay in the examination of electronic devices did have an impact on professionals being able to know whether or not the children had been sexually abused and to understand more clearly the risks that Mr W posed. There was very little contact between the Police and CSC from this point onwards. Each agency continued on with their own core task; the police the investigation of the crime and CSC with the plan to address the needs of the children through a multi-agency CIN process; joint sharing of knowledge and expertise could have in part mitigated the delay in the forensic information. This is discussed further in Finding 1.

2.15 SW2 undertook an assessment of the children and their circumstances. The assessment was concluded quickly and its quality was hampered by the high turnover of social workers and capacity issues within the team. It was over optimistic in its conclusions, was not based on the concerns shared by the schools and focused too much on the needs of the adults whose views were reported verbatim without analysis; this is discussed further in Finding 4. SW2 did not liaise with the police and therefore the concerns about both the risk posed by MR W and Mother's lack of acknowledgement of those risks were not included. SW2 also

interpreted the delay in the forensic examination as meaning no assessment of Mr W could take place because of concerns regarding the influence on any potential criminal proceedings. This was incorrect. It was the expectation that this assessment would use all the available information and expertise to make sense of the risks posed by Mr W and the ability of Mother to effectively protect the children, which could be revised when more information became available. No analysis took place of either risk and this is addressed in Finding 1.[12]

2.16 The assessment was also supposed to have analysed the considerable historic and current multi agency concerns regarding neglect, but it did not and this is addressed in Finding 5.

2.17 SW2 proposed that there was no need for an Initial Child Protection Conference (ICPC) because the evidence collected through the assessment process suggested that a child in need[13] (CIN) plan would address the identified needs of the children. This decision was made on the expectation that there would be a clear, formal CIN process, with a robust plan, clear goals, a focus on outcomes and a clear review process given the level of uncertainty about the current risks mechanism. This did not happen and this is discussed in Finding 6. The assessment was not shared with any of the agencies involved which meant that inaccuracies could not be challenged and the basis on which the CIN plan was to be formulated was not known by all agencies that were to provide services. This was caused by confusion about whether assessments could be shared and this is discussed in Finding 6 in the context of CIN plans.

2.18 The plan not to convene the ICPC was agreed by the Child Protection Chair who informed all other agencies. The decision was taken without discussion with the professionals who knew the children and their circumstances well (the schools), who would have disagreed, and without discussion with the Police, whose risk assessment was predicated on the notion that there would be a child protection plan in place regarding the children and were joint partners in the child protection inquiry. This was not an appropriate decision and it is the view of the Review Team that the ICPC was necessary to ensure the safeguarding of the siblings; that their circumstances met the criteria for the likely risk of significant harm because of the uncertainty regarding the risk posed by Mr W and the concerns regarding Mother's capacity to recognise the potential risks and keep the children safe.

[12] http://www.saferchildrenyork.org.uk/protecting-children-online.htm

[13] Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures is Government guidance which describes **good** practice in relation to the interviewing of and giving of **evidence** by vulnerable witnesses (children and vulnerable adult witnesses). https://www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf

2.19 This Review has been reassured by the Review Team's local knowledge that deciding to work at CIN level rather than at the Child Protection level where risks to children remain uncertain, and a multi-agency response is required, is not currently routine practice in Wiltshire. In this case it appears to have been influenced by the over optimism of the assessing social worker and poor management oversight. It is clear that the ICPC was required, given the level of uncertainty about the risks posed to the children, but it would also have been expected that a clear and robust CIN process would have been put into place. This did not happen and this is addressed in Finding 6.

2.20 The decision to cancel the ICPC was challenged by the police and Sibling 5's school. The Police reiterated their concerns about the risk Mr W posed, and concerns about Mother's ability to protect. Although it was appropriate that both agencies challenged this decision, they should both have pursued the matter further. The issue of appropriate professional challenge and use of the Escalation Policy is addressed in Finding 3.

## The First Child in Need Meeting

2.21 At the end of September, the first CIN meeting was convened. This was an important opportunity to consider the needs and circumstances of all five children. This was chaired by SW2 and attended by representatives of the children's schools, the School Nurse, Mother, Mr W and Sibling 4's Father. The concern that Mr W had downloaded indecent images of children was discussed, but the detail was not. This appears to have been influenced by Mr W's presence at the meeting. There was no discussion about the appropriateness of Mr W attending the meeting, given the continued lack of knowledge of his actual offending behaviour or the exact risk he might pose in the context of grooming, and how he might use attendance at any meeting as an influencing factor with the children. This is discussed in Finding 1.

2.22 Mother was asked to give an outline of the circumstances of each child and her overly optimistic view was in sharp contrast to the information provided by the agencies present. This discrepancy was not addressed or discussed and the issue of an uncritical and unanalytical acceptance of parental views is addressed in Finding 4. The impact of this on professional's ability to analyse and name neglect is addressed in Finding 5.

2.23 A CIN plan was formulated and focused on a number of practical issues:

- head lice and school attendance for Sibling 2
- a school place for Sibling 1 (Mother had failed to complete the application in a timely way and no place was available at the school attended by the siblings)
- "keep safe work" for all the children (this was never implemented)
- a referral to the Young Carers Project for Sibling 5

- a referral to a Family Group Conference (FGC) regarding supervising contact between Mr W and the children in the future.

These actions were formulated in the absence of a clear outline or analysis of the central concerns for these children; which was evidence of neglect and possible sexual abuse.

2.24 The CIN process and plan was further undermined by the fact that soon after it was developed SW2 left. As there was no allocated social worker for the children the CIN plan was overseen by different social workers from the Duty Social Work Team. There was also a turnover of school nurses at the same time and so actions agreed for these two agencies did not take place. Continuity was provided by the children's schools, but they had not been tasked with any actions within the plan.

2.25 In October 2014 the nursery was worried about Sibling 1 (aged 4 and a half) soiling himself, being distressed and Mother's dismissive attitude towards him. There were similar concerns from school regarding Sibling 2 and head lice. Contact was made with the Duty Social Work Team and information shared although there was no action agreed. This was due in part to the fact that School 1 and the nursery were not as clear as they could have been with regard to concerns about long term neglect (See Finding 5), and because there was no allocated social worker.

2.26 In mid-October 2014 the police and housing services became aware that there were allegations that Mother might be allowing Mr W to have contact at home with the children; this breached both the bail conditions and written agreement. This was followed up by a Duty Social Worker (SW3). Mother said the children had no unsupervised contact with Mr W but she said she had been meeting Mr W in the evenings and had been told by the previous social worker that she was allowed to do so. This was continued evidence that Mother either did not understand the bail conditions/working agreement, or was choosing to disregard them. Either way this required analysis and action. During this visit the Duty Social Worker (SW3) noted that the house was unkempt; dirty and dishevelled; two young people (aged 19 and 17) were asleep on the sofa and there was evidence of empty bottles of alcopops on the floor. YP1 was also at the house. Although these concerns were discussed with Mother, the considerable ongoing concerns regarding the neglect of these children was not addressed.

## A second strategy meeting

2.27 At the beginning of November 2014 a new social worker was allocated to work with the family (SW4). Sibling 1's nursery reported to her that Sibling 1 had said "*daddy was arrested with handcuffs…because he touched us and he was not allowed*". It has now become clear that these were not the words used by Sibling 1, but things he indicated had happened using nonverbal language. This was another example of inaccurate and potentially

misleading recording of children's views in the context of concerns around abuse which is discussed in Finding 2.

2.28 A further strategy meeting was convened and it was agreed that there would be a joint police and CSC child protection inquiry. The strategy meeting did not consider the verbal abilities of Sibling 1, which were delayed, and given his age, it would have been expected that there would have been discussion and planning about how best he could be supported in interview and to perhaps include a member of nursery staff. Sibling 1 was seen alone; his speech delay was noted and it was concluded that he did not have sufficient verbal skills to talk about what he had reportedly talked about at nursery. No action was agreed to address this. The other children were also interviewed, but there is no detail about what the focus of this interview was or what they actually said beyond that they expressed no worries or concerns. This continued lack of a clear or robust approach to interviewing children about abuse is discussed in Finding 2.

2.29 Mother again denied that Mr W had any unsupervised contact with any of the children, but that he had been at the house helping to decorate when the children were not there. She said she had been told this was acceptable by the previous social worker. This was a similar discussion to the conversation with SW3 10 days earlier and should have raised alarm bells, both about Mother's understanding of the risk posed by Mr W and her ability to ensure the safety of the children, and the degree to which she may have been attempting to deflect professional attention. Contact was made with the schools, who again shared their continued concerns. However, the child protection investigation only focused on the one incident, rather than taking a holistic view of the current circumstances, and continued to lack a focus on the real issues, which were risk of sexual abuse and concerns about neglect. The conclusion of social work was that the CIN process should continue. This was not communicated to any other agency; rather the schools had to contact SW5, where they expressed concern that the child in need plan was not being fully implemented.

## Child in Need Plan continued

2.30 In mid-November 2014 SW5 assessed PGF's suitability to supervise contact between Mr W and the children. SW5 was concerned that PGF seemed to be unaware of the detail of the offences and significantly minimized what had happened. Although SW5 appropriately recommended that PGF should not supervise contact, she did not ask about whether other children visited the family home when Mr W was present and the safety of the children in the wider extended family was not assured (see Finding 1).

2.31 The second CIN meeting was held in December 2014. Much of the discussion was about Sibling 4, who had moved to live with his Father. Professionals agreed that Sibling 4 seemed more settled, happier and healthier since the move. There was no discussion about the

implications of this for the care he had previously received and the link to neglect not discussed. This was despite there being continued concerns regarding head lice for Sibling 2, speech delay for Sibling 1, and Sibling 4 and 5 taking on what were described as caring responsibilities. The issue of distinguishing between appropriate early caring responsibilities and neglect is addressed in Finding 5.

2.32 School 1 and school 2 also expressed the professional view that the children were being coached by adults about what to say to professionals. It is of concern that there was no deliberation about this within the CIN meeting, or action to address it. The implications of this on the ability of children to make disclosures and seek help from professionals are considered in Finding 2.

2.33 There was also no discussion regarding the continued risk of sexual abuse including:

- lack of progress of the police inquiries;
- Mother's continued testing of the terms of the written agreement;
- worries that MR W might be visiting the home;
- The family/PGF's lack of explicit knowledge or acknowledgement of the concerns about sexual abuse.

2.34 Overall the CIN process had made little progress and the plans lacked a focus on an analysis of the children's circumstances, the potential challenges to their outcomes, and contained little acknowledgement of the major issues. This lack of robustness in the CIN process is discussed in Finding 6. There was no further discussion of YP1.

2.35 In January 2015 SW6 became the new allocated social worker and the family were discussed in her supervision with ATM 1, where the issues of drift in the CIN plan was acknowledged. It was agreed that the CIN plan would be reviewed and should become more child focused. It was agreed that there would be an assessment of Mother's ability to recognise the potential risks posed by Mr W and keep the children safe, alongside an overdue assessment of Mr W and the likely risk of sexual abuse he might pose. More work regarding the circumstances of YP1 was also agreed. These were all appropriate actions, but none actually happened despite being discussed in subsequent supervision sessions. This lack of progress was caused by the ongoing high caseloads and pressures on the team.

2.36 During January a number of agencies shared information with SW6 including:

- the poor condition of the home and garden from housing;
- Sibling 2's chronic and painful head lice and concerns regarding Mother's attitude and lack of action;
- Sibling 5 being upset at school and Mother warning her not to talk to the Pastoral Support Team.

School 2 asked that this be dealt with sensitively because Sibling 5 was very worried about SW6 telling Mother that she had been talking about family life and would be angry with her. This concern from a young person about sharing her worries with professionals, because of a likely negative response from a parent, required more reflection and discussion. It is essential that young people are enabled to seek help when they need it and to build trust with professionals which will support disclosures about more sensitive issues, such as sexual abuse. This is discussed in Finding 2.

2.37 SW6 focus at this time was on forming a relationship with Mother and getting to know the children. She spent time doing child focused activities but these lacked a clear purpose and the information gathered reflected a different version of family life and circumstances than that known and seen by the schools. This should have been discussed in the context of the CIN meetings and in an ongoing analysis of the children's needs and circumstances. This did not happen and the lack of analysis within the child in need process is discussed in Finding 6.

2.38 The third CIN review meeting took place at the beginning of March. This was an opportunity to review progress after a time of drift and a number of worrying incidents. It should also have been a time to review what was known about Mr W's offending and the risk he posed. None of this happened. A worrying picture of the children's current circumstances emerged and information that Mother had a new partner was shared. Once again there was no analysis of the children's circumstances.

2.39 A referral was made to the Family Group Conference service in mid-March and the Family Group Conference (FGC)[14] took place in April 2015. Rather than discussing the ongoing concerns about how Mother was coping and the various needs of the children, the FGC focused narrowly on supervising contact. Mother and Mr W did not provide details about the wider family network. Consequently, there was no representation at the meeting of Sibling 5 or 6's Fathers or any other member of the paternal family who had children, for whom the implications of supervision by family members was relevant. Limited professional information was provided to the conference and the negative assessment of PGF was not shared. The FGC plan focused entirely on practical issues, and the plan produced did not answer the central question about how to make these supervisory arrangements safe. PGF was asked to supervise contact. This plan should not have been agreed by SW6 as it was not safe and this again raises questions about professional understanding of offending behaviour discussed in Finding 1. There was also no discussion about whether it was safe or appropriate for Mr W to attend.

[14] A family group conference is a process led by family members to plan and make decisions for a child who is at risk. Children and young people are normally involved in their own family group conference, although often with support from an advocate. https://www.frg.org.uk/involving-families/family-group-conference

2.40 During May 2015 School 3 became increasingly concerned again regarding Sibling 1's soiling; his distress, the unhelpful attitude of Mother and the fact that he often returned to school with the same pants on that he had soiled and which were still dirty. The school's Designated Safeguarding Lead (DSL)[15] and the Teaching Assistant contacted SW6 and expressed their concerns that this behaviour was indicative of sexual abuse. SW6 came to the school and met with Sibling 1; she formed the conclusion that this was a toileting issue and ATM1 agreed with this analysis. School 3 worked hard to suggest that a different analysis was required. This issue of the importance of the appropriate management of professional disagreements is discussed in Finding 4.

2.41 The fourth CIN meeting took place at the beginning of May 2015. The same concerns regarding the children were discussed and although it was clear that there were continued differences of professional opinion regarding the children and their wellbeing, these were still not explicitly discussed or analysed. It was reported that Mother had a new partner. Despite the lack of progress or change, SW6 suggested that the children did not need ongoing social work support and that the children would no longer be subject to child in need plans. The schools and nursery expressed unhappiness about this and expected that this would influence the outcomes. It did not, and the same concerns remained which were not addressed over the next three months. The lack of robustness of the CIN process continued and is discussed in Finding 6 alongside the continued difficulties that professionals had in resolving disagreements about the wellbeing of children; discussed in Finding 3.

2.42 In August 2015 the single assessment[16], planned in January, was completed. This assessment was supposed to address the risks posed by Mr W and establish the extent to which Mother could keep the children safe. Because the assessment took 8 months, the ongoing concerns held by the school and nursery, were not sufficiently addressed and there was no mention of neglect. The assessment was not shared with the professionals working with the children, and therefore they were not able to challenge its contents. In supervision, SW6 and her manager agreed that the CIN plan would end after the next CIN meeting. The rationale was that there were a number of agencies who were addressing the children's needs and the police inquiries would not be completed for some time. There was pressure on the teams at this time to ensure all work with families was focused and necessary because of the volume of work. For these children, there was an incorrect analysis of the

[15] The role of the **Designated Safeguarding** Person was specified in the Children Act 2004 and ensured the every organisation had a "named person" for **safeguarding** children and young people. Prior to that, the role had frequently been known as the Child Protection Officer.

[16] A Single Assessment is an in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or carers to respond appropriately to these needs within the wider family and community context. While the Single Assessment is led by Children's Services, it will involve other agencies or independent professionals, who will provide information they hold about the child or parents, contribute specialist knowledge and/or give advice / undertake specialist assessments.

risks and needs held by CSC, compounded by poor assessments, poor plans and a lack of recognition of the expertise of the multi-agency network, who held knowledge about neglect of the children (schools and nursery) and sexual offending (police).

2.43 In August 2015 professionals became aware that Mother was pregnant by her new partner. There was some multi-agency discussion regarding this, and as there were no concerns regarding the pregnancy or the new partner it was agreed that the midwifery team would be in contact if further concerns emerged.

2.44 The next CIN meeting was amalgamated with the review Family Group Conference, which meant that the CIN plan was not discussed as the focus was on the completely separate FGC plan. The Coordinator of the FGC was completely unaware that the review FGC was also being used as a CIN Meeting and would not have agreed to this. This appears to have been a one off incident and therefore, although it was inappropriate and unhelpful to the children, no specific action is proposed as a result of it.

2.45 The next CIN meeting was held in October 2015. It was chaired by SW6, attended by Mother, Mr W and two new professionals from School 1 and the School Nurse Team. The discussion focused on current behavioural difficulties of the children and strategies were suggested. The previous plans, and the lack of progress of some elements, were not part of the discussion. The professionals present were asked whether they agreed with the case closure and step down to support from a CAF. Neither professional knew the family well enough to comment and the professionals who did know the children and were not present at this meeting, were not asked beforehand. Nevertheless, the CIN plan ceased and no CAF was formulated, with the result that the children no longer had any formal status within the multi-agency system. School 2 and School 1 expressed concern when informed about this but were told they could not influence the decision.

2.46 In early November 2015 there were escalating concerns regarding Sibling 5 from school 2, including Sibling 5 running away from home overnight and a disclosure that Mother had been physically abusive to her. This was reported to the Duty Team because SW6 had left by this time and there was no longer an allocated social worker. The Duty Social Work Team asked the school to discuss this further with Sibling 5 and a referral to youth support was proposed. No further action was taken and the school continued to support Sibling 5.

2.47 In January 2016 Sibling 5 returned to school and made further allegations that Mother had been physically abusive to her and she was encouraged to provide a written statement, which was good practice and supportive of Sibling 5 having her concerns recognised. A referral was made to CSC who advised that a single assessment would commence. Sibling 5 exhibited huge anxiety about her Mother being told about the allegations she had made and

shared that Mother had told her that she would also assault the Pastoral Support Manager if she discussed this with her.

2.48 The Pastoral Support Manager appropriately discussed this with the Duty Social Worker (SW7) and asked that a social worker come and talk to Sibling 5 (aged 14) before seeing Mother, to provide information and reassurance regarding her disclosure. The social work Assistant Team Manager (ATM1) said that a social worker could not meet with Sibling 5 without Mother's consent. The school were unhappy with this proposal but felt helpless to do anything about it; this is discussed in Finding 3. Consent was sought, but not agreed by Mother, who said Sibling 5 was making malicious allegations. Mother was visited at home by the Duty Social Worker (SW7) and denied the allegations of physical abuse. It is of concern that Sibling 5's concerns about the impact of making a disclosure were dismissed without further discussion and this is addressed in Finding 2.

2.49 A week later the police forensic investigation was completed and Mr W arrested and imprisoned. The children were made subject to child protection plans and Care Orders sought. The proceedings have concluded that the children will not return to their mother's care.

# 3 The Findings

## Introduction

3.1 This section contains 6 priority Findings that have emerged from this SCR. The findings explain why professional practice was not more effective in protecting the siblings in this case. Each Finding also lays out the evidence, identified by the Review Team and Case Group, that indicates that these are not one-off issues, but are matters that if not addressed could cause risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs.

## Summary of findings

3.2 The Review Team have prioritised 6 findings for the WSCB to consider. These are:

| | Finding | Category |
|---|---|---|
| 1. | The exponential increase in the number of men who view online child sexual abuse images is not matched by the development of knowledge of best professional practice, leaving professionals uncertain how to respond and children at continued risk of harm. | Professional norms and culture around communication |
| 2. | The absence of a clear framework for when interviews with children take place outside of the established ABE process, alongside the pressures to balance the requirements of evidence gathering with the need for child sensitive approaches, can lead to inconsistency and unclear interview approaches. | Management systems |
| 3. | Appropriate routine professional challenge and the use of escalation processes is insufficiently embedded in the multi-agency network in Wiltshire; leaving differences in professional opinion unaddressed and causing feelings of "learned helplessness" which in turn makes resolution less likely. This undermines the safety and wellbeing of children and does not support action to address concerns. | Professional norms and culture around communication – longer term work |
| 4. | There is a tendency for professionals to uncritically accept what parents tell them about their children in the mistaken belief that this is "working in | Patterns of interaction with families |

| | | |
|---|---|---|
| | partnership", resulting in an inaccurate description of children's needs and circumstances which are left unaddressed as a result. | |
| 5. | The lack of an effective practice framework for working with neglect in Wiltshire has left professionals deskilled in their response and inconsistent in how they explicitly name child and adolescent "neglect". | Tools |
| 6. | Although there have been changes to the way in which Child in Need processes are delivered in Wiltshire, there appears to be continued evidence that they lack a multi-agency approach and the rigour and focus seen in child protection processes is missing, with the result that there is insufficient analysis of children's needs. | Professional norms and culture around communication – longer term work |

**Finding 1: The exponential increase in the number of men who view online child sexual abuse images is not matched by the development of knowledge of best professional practice leaving professionals uncertain how to respond and children at continued risk of harm.**

**Introduction**

*"Possession of indecent images of children is alarmingly commonplace" (*CEOP 2012[17])

3.3 This Finding focuses on the extent to which all professionals feel equipped to recognise, assess and address the risks posed by adults (usually males) who download child abuse images. There has been an exponential increase in the number of men who possess indecent images of children, including images of rape and sexual assault. This is both locally in Wiltshire and nationally. It is clear that the act of downloading and possessing images of children being abused is not a passive activity. Watching children being abused by others is child abuse and should be appropriately challenged. Children are the victims of sexual abuse when the images are produced, and they remain victims every time the images are viewed; the knowledge for some that these images can be repeatedly seen by many people causes ongoing trauma.

[17] https://ceop.police.uk/Documents/ceopdocs/CEOP%20IIOCTA%20Executive%20Summary.pdf

**How did the issue manifest itself in this case?**

3.4 The early strategy meeting in September made clear that there were significant concerns that Mr W posed a risk of sexual abuse to children. It is of concern that although it was known for certain that he had chosen to watch young children being sexually abused this was never described as sexual abuse; the only action taken against him was the Police Investigation and he was not held responsible for the abuse of these unknown children or the disruption and distress he caused to his own children/stepchildren. Professionals did not discuss this issue, and perceived Mr W's actions as evidence of passiveness, rather than active abuse. The language professionals then used to describe what was happening in records then either reinforced this passivity, minimized it or normalized it; thus watching children being sexually abused was often referred to as watching "child pornography" a phrase that is widely used nationally, but which undermines a true picture of the harm.

3.5 There was never an assessment of the risk posed by Mr W. Initially this was because the social worker at the time incorrectly believed no assessment could take place whilst the police investigation was ongoing. The urgent need for an assessment of Mr W was then lessened because he was bailed to live away from home, but there was considerable evidence over time that he spent time at the house; there was no evidence that he had contact with the children, but Mother made it clear that he continued to play some part in family life. An assessment of the risk he might pose was necessary. Over time this need was discussed, but no assessment ever took place.

**No assessment of Mother's Ability to Protect**

3.6 The initial assessment process did not assess Mother's ability to protect the children at the time of the initial child protection investigation or at any point during the next 17 months, despite immediate concerns regarding her ambivalence and dependency on Mr W. In the first assessment Mother and Mr W were interviewed as a couple together, and there was no discussion about how Mother might cope financially or practically with Mr W absent.

3.7 Mother consistently questioned the terms of the bail conditions and there were concerns that Mr W was visiting the home and then proof was obtained that he was. Reassurance was provided by Mother that this was only when the children were not there and for the purposes of decorating or talking about the children. Research[ii] is clear that a Mothers' ability to protect children from likely offenders is linked to the ability to separate emotionally and practically from the perpetrator. Mother never did this, and the implications for the care of the children were not assessed in an ongoing way. When Mother started a new relationship there was some reassurance, but Mr W continued to attend meetings. Although there was evidence that this new partner had associates who were sexual offenders, this too was never assessed.

3.8 Over and above the early interviews with the children, there is no evidence that issues of sexual abuse and keeping themselves safe was ever discussed. At the first CIN meeting it was agreed that the children would be referred to a "Keep Safe[18]" programme – but this was never actioned. It was only Sibling 4's Father who put some boundaries in place and stopped all contact for Sibling 4 with Mr W supported by the courts. Early on it was clear that PGF did not take the concerns seriously and did not recognise the risks that his son could pose. This was not addressed in regards to how seriously the whole family took these risks.

3.9 This lack of understanding and/or knowledge of the seriousness of the issue meant that it was not possible for the wider family to ensure that Mr W did not engage in a grooming or coercive manner to the siblings or other children in the family. Indeed, when a Family Group Conference was organised only some members of the family were invited, and no details of the offences were shared. In this context, the family were tasked with creating a safe plan for supervising contact between Mr W and the siblings although they did not have enough information on which to base such a plan. Other children in the family were not included and therefore not safeguarded.

3.10 Finally, there was no discussion, in the context of grooming processes and the use of adult authority, whether it was appropriate for Mr W to attend meetings about his biological children (Siblings 1 and 2) or other children within the household (Siblings 3,4 and 5). The fathers of the other siblings were not asked about this, and Mr W attended many meetings, including the Family Group Conference, where sibling 5 was present. If Mr W was grooming her or coercing her, this put him in an unhelpful position of authority. This risk should have been discussed as part of a much wider safety plan for the children. The absence of a clear approach to sexual offending meant that this did not happen, compounded by the poor decision at the time to cancel the child protection conference and place the children on Child in Need plans.

**How do we know the issue is underlying?**

3.11 Because this Finding concerns the professional knowledge-base in relation to sexual offending and sexual abuse it is one that is highly likely to occur across other casework that has a similar profile. At best, in the absence of any framework or practice guidance, it makes good practice reliant on the knowledge and experience of individual professionals, particularly the social workers that lead the multi-agency work at statutory level.

**How widespread is the issue?**

3.12 There is an absence of advice, guidance, tools or framework for the multi-agency child protection network nationally, so it is likely that this issue will be replicated more widely

[18] Specialist group work programme

than Wiltshire. It is not specifically addressed in Working Together 2015[iii] and only Essex and London[19] LSCBs have produced practice guidance in England. This appears to have left child protection professionals aware that those who download sexual abuse images pose significant risks to children, but often unclear about how to assess the risk these adults pose; how to assess whether another adult/parent is able to protect children and how best to ensure children are not groomed.

3.13 There are specialist assessment frameworks that have been developed, but these have not been integrated into mainstream safeguarding practice. Any assessment needs to take into account the work of Finkelhor (2008[iv]). Finkelhor's theory suggests that there are four factors that need to be met for someone to sexual abuse children. These are:

- the motivation to abuse a child – and that is often described as a sexual interest in children;
- the overcoming of internal inhibitions against acting on that motivation; the downloading images of child abuse is considered to be a way of reinforcing cognitive distortions about the sexual abuse of children. (Some other theorists think that viewing these images might reduce the likelihood of offending because they are a way for adults to control these urges).
- Overcoming external barriers and finding a way to come into contact with children in circumstances where they are not appropriately supervised, where children are vulnerable because of their circumstances and where other adults are unable or unwilling to intervene to protect a child. Recent research has suggested that there is a strong link between child neglect and sexual abuse for this reason. This is why assessing the ongoing capacity of any adult responsible for keeping children safe is imperative.
- Overcoming the resistance of the child. Sexual offenders target vulnerable children and are practiced at being able to abuse a child through grooming processes which may employ adult authority, coercion and control. That is why limiting access to children is important and why professionals must be aware of not supporting behaviours which reinforce adult authority, such as attendance at key meetings about children or being given tasks in plans which enable the likely perpetrator to display adult authority.

3.14 Finkelhor[v] suggests that all four pre-conditions need to be met before a perpetrator will abuse children and that understanding and assessment of all four areas is important in understanding risk and harm.

**Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.15 Assessments deal with the potential for harm/safety posed by individuals, not just what can be evidenced as fact. Doing them well involves gathering what information is available from

[19] http://dera.ioe.ac.uk/2028/1/final_cads_guidelines.pdf

different sources, both within the multi-agency professional network and from family members, then assessing what picture that information is painting of the individual concerned. Judgements are made, not so much on the basis of harmful behaviours that are known, but the probability that harmful behaviours will occur. Current debates within the child protection arena have focused on whether downloading abusive images will lead to offenders sexually abusing children. The research is not clear, but work by CEOP suggests that there is a clear correlation between downloading sexual abuse images and sexual offending against children; although a clear causal pathway cannot be established. The research suggests that it is important to assess the risk that each individual poses, with the presumption that each is a potential sexual abuser, but professionals are not well enough supported at the moment to be able to do that with confidence.

| **Finding 1: The exponential increase in the number of men who view online child sexual abuse images is not matched by the development of knowledge of best professional practice leaving professionals uncertain how to respond and children at continued risk of harm.** |
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| The downloading of images of children being sexually abused is a serious and growing problem. The absence of appropriate guidance, assessment tools and a professional workforce who lack knowledge of the best way to work with this threat leaves children at risk of harm. |
| **Questions for the Board**<br>• Do the Board recognise that this is an issue that needs addressing? How big an issue might it be for Wiltshire?<br>• What immediate action needs taking to address the gap in knowledge across most of the multi-professional network?<br>• What expertise can the Board access to address this Finding?<br>• How will the Board know it has been successful? |

**Finding 2: The absence of a clear framework for when interviews with children take place outside of the established Achieving Best Evidence (ABE)[vi] process, alongside the pressures to balance the requirements of evidence gathering with the need for child sensitive approaches, can lead to inconsistency and unclear interview approaches.**

**Introduction**

3.16 The central purpose of any child protection inquiry is to discover whether children have been harmed, in what way and by whom. This is achieved through comprehensive assessments and analysis of a child's circumstances which includes talking to children, parents, wider family members and other professionals. Interviewing children is an essential part of this process.

3.17 Local and national guidance makes it clear that children must be offered an opportunity to be interviewed sensitively and enabled to "tell their story" as well as disclose concerns and harm. This process is not easy for children and research by the Office of the Children's Commissioner[vii] suggests that as few as one in eight victims of child sexual abuse come to the attention of professionals and many victims wait until adulthood before being able to tell someone about their experiences. Research by the NSPCC[viii] suggests that this is not because the children do not seek help, but because they are often not heard, not believed, or adults do not notice the behavioural signs that indicate something is going on for them.

3.18 Where there is a strong suspicion that a crime has been committed these interviews will be visually recorded and undertaken by specially trained police officers and social workers under the Achieving Best Evidence in Criminal Proceedings Guidance[20]. This guidance provides a structured approach to interviewing. Serious thought is given to the appropriateness of using this very formal process, as it may be difficult for children. However, good practice suggests that regardless of the process of the interview, they must be planned carefully, the individual needs of the children taken into account, and the support they need provided. The Achieving Best Evidence Interview Framework is a useful guide to any type of disclosure interview, providing a framework which is mirrored in most good practice guidance about conducting direct work with children.

3.19 It is also essential that interviews are sensitively recorded, and that records provide information about the focus of the interviews, barriers to success, what was asked and what children actually said, using their own words. Accurate recording is necessary as the information might be used in criminal proceedings or as part of legal proceedings regarding where a child will live and with whom, and is part of a process. Children may be interviewed on more than one occasion, and it is important that professionals are aware of what was said in previous interviews in order to build trust and rapport with a child.

3.20 During interviews with children professionals need to balance the rules and requirements of evidence gathering, which requires thought about questions to be asked and who might be involved, with the need to ensure that the interviews are child centred and enabling of children's disclosures. This is tricky to achieve, which is why a clearly planned and structured approach making best use of those people who know the developmental needs of the children is necessary.

[20] This Guidance describes good practice in interviewing vulnerable and intimidated witnesses, both adults and children, in order to enable them to give their best evidence in criminal proceedings. http://lx.iriss.org.uk/sites/default/files/resources/066.%20Achieving%20Best%20Evidence%20-%20Guidance%20Vol%201.pdf

**How did the issue manifest itself in this case?**

3.21 The five siblings were subject to child protection inquiries on two occasions. At the start of the first inquiry there were significant concerns that the siblings may have been sexually abused or been involved in watching inappropriate and indecent images of other children being abused. Appropriately, interviews were agreed. It was decided initially that it would not be appropriate to subject the children to the formal ABE process, and that this would happen if they made any disclosures of harm.

3.22 For the four oldest children, these interviews took place at school. The schools knew the children well and had long term concerns about their vulnerability and wellbeing. The expertise of the schools should have been used to plan the interviews. It is hard to know how the interviews were planned, how the developmental needs of the children were to be addressed, what was asked of them and what they said, as the recording of the whole Section 47 child protection inquiry was superficial and this information was not included. It is clear that the school were concerned that the interview process was unsettling and upsetting for the children; it would have been expected that there would have been a conversation with key school staff before the interview to plan appropriately, and after the interview so that the school staff could support the children.

3.23 The interviews were not undertaken in an optimal or planned way, and it is of concern that this led to the view that because the children had made no disclosures, that no abuse had occurred. This view was confirmed in the closing summary by SW2. This put too much responsibility on the children, given that there were other concerns about Mr W's and Mother's attitude and denial, and also over time there were behavioural indicators that suggested that all was not well. There was little reflection or analysis of the possibility that during a brief, unstructured interview with a stranger, that these young and vulnerable children may not be able to say if any harm was occurring to them, either because of their developmental needs or through a process of grooming and coercion.

**How do we know it is underlying?**

3.24 Any interviewing of children that is not done under the formal ABE structure is subject to differ in style and rigour according to team practices at any given time – or in other words, becomes 'the way we do it here'. There is always the possibility that practice in these circumstances will be good but it was not at the time of this review, which has found no persuasive evidence that practice now would be particularly different to practice then.

**Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.25 Children need professionals to provide the best opportunity for them to be able to talk about any abuse they have experienced, in order that those professionals can form a view that is drawn from a child's 'lived experience' as to the degree to which it is harmful for

them to remain at home, with support or at all. There is a human tendency for all professionals to be swayed by information provided by adult parents (see Finding 4). There are many reasons for this, including the more extreme scenarios whereby the parent is particularly adept at manoeuvring around professionals and/or because the professional over-empathizes with the position the adult parent is in. Only a child will know how they feel; for assessments to be able to work effectively with them in their family context, that child needs to be supported to communicate safely in whatever way comes most naturally to them.

| **Finding 2:** |
| --- |
| **The absence of a clear framework for when interviews with children take place outside of the established ABE process, alongside the pressures to balance the requirements of evidence gathering with the need for child sensitive approaches, can lead to inconsistency and unclear interview approaches.** |
| It is essential that all professionals feel able to talk to children about safeguarding issues and that this happens in a clear and child focused manner. Currently training is provided to Professionals conducting ABE interviews, which provides them with a clear framework and support before they are able to interview children in this setting. Those trained in ABE techniques are usually only a proportion of the numbers of practitioners who may need to talk to children about their living situation at any given time. The ABE rigour does not apply in these situations, making non-ABE interviewing vulnerable to individual style and shortcuts. |
| **Questions for the Board**<br>• How confident are Board members that practitioners tasked with communicating with children have the necessary skills to do so?<br>• What kind of support might be most effective and who needs it most?<br>• How might those who have received ABE training support those in their organisation (and beyond) who have not; is there scope to capacity build locally? |

**Finding 3: Appropriate routine professional challenge and the use of escalation processes is insufficiently embedded in the multi-agency network in Wiltshire, leaving differences in professional opinion unaddressed and causing feelings of "learned helplessness" which in turn makes resolution less likely. This undermines the safety and wellbeing of children and does not support action to address concerns.**

**Introduction**

3.26 This Finding is about the way in which professionals who work across the safeguarding continuum are able to manage and resolve professional differences and disagreements. These disagreements and differences are inevitable given the complexity of the territory to

be navigated, the propensity for human bias and fixed thinking alongside the influence of working with a small minority of adults who may have reasons to manipulate and distort the truth. Establishing a culture of openness to change, to constructive challenge and self-criticism is fundamental to addressing these issues. Reder and Duncan (1999)[ix], as a result of their review of Serious Case Reviews nearly twenty years ago, argue that front-line staff need to develop 'a dialectic mind set' in which there is a constant balancing of opposing arguments, alternative hypotheses or conflicting versions of events.

3.27 If these inevitable disagreements cannot be resolved professionals can become helpless and de-skilled. Learned helplessness[x] is a psychological concept which describes a process or state of mind whereby an individual's previous experience of unexpected failure, or failure which makes no sense, has a negative effect on future decision making and beliefs about success which can cause paralysis and uncertainty. Essentially, individuals can feel like they can exert little or no control over their own environment or the decisions or actions of others despite knowing that something different needs to be done. When this is unaddressed it can lead to feelings of helplessness and failure, and reduces people's confidence and belief in their ability in their role and task.

**How did the issue manifest itself in this case?**

3.28 In September 2014 at the very start of this review a number of different agencies were involved in the original strategy meeting regarding the threat of sexual abuse that Mr W might pose. This meeting agreed that the children were at risk of significant harm and that it was appropriate for there to be a multi-agency Initial Child Protection Conference to consider those risks and plan for them. However, as a result of the assessment carried out by CSC a decision was made by CSC alone that the conference would be cancelled and the children would receive a Child in Need service. This happened without any discussion with any other agency and without taking account of their concerns regarding the children. The police and schools appropriately challenged this decision but this challenge was limited and not pursued.

3.29 Over the next 13 months there were numerous occasions when there were disagreements about the nature of the risks facing the children across the multi-agency network. There was little routine discussion of them and they remain unresolved. The school attended by Sibling 2 did not consider that the issue of Siblings 2's nit infestation and Mothers lack of action was ever taken seriously enough; this was raised with social workers, but never resolved. School 2 were concerned about Sibling 5 and Mother's physical and emotional abuse to her as they saw it, but this was never adequately addressed.

3.30 In all these situations, the agencies were frustrated and concerned on behalf of the children and although they voiced those concerns over time, nothing changed. Contact was made with the Assistant Team Manager to attempt to resolve the difficulties over time, but this

also made no difference. No agency used the Wiltshire Safeguarding Children Board Escalation Policy[21] and all agencies felt a sense of helplessness regarding what they could do and felt their own understanding of the children's circumstances was undermined. Each of the schools were unhappy with regard to the children's safety and wellbeing but could find no way of getting their individual voices heard.

3.31 The Wiltshire Safeguarding Children Board has a framework for resolving disagreements and this emphasises that the interests of children must take precedence over a professional stalemate. This did not happen in this case; partly because all agencies were not aware of the processes in place to resolve disagreements, but also because over time their confidence in their own analysis of the children's needs and circumstances was eroded when they tried to advocate on the children's behalf. Routine attempts through discussion and debate were tried and failed, and no one professional was able to step back and point out that when considering the needs of the children where there are such variances in the understanding of children, as there was in this case, it is likely that no one agency individually or collectively understood the needs of the child/ren or the risks they faced. This required a complex case meeting or process.

**How do we know it is an underlying issue and not something unique to this case?**

3.32 Locally, the Case Group recognised that there were many occasions where disagreements regarding children existed, but where it was not possible to resolve them. There was a lack of awareness of the WSCB escalation processes.

**How prevalent and widespread is this issue?**

3.33 This is an issue which has been recognised nationally as of concern, from the collective review of Serious Case Reviews by Reder and Duncan in 1999[xi], to the most recent Triennial Review of SCRs (Brandon et al, 2016[xii]). It was an issue in the Victoria Climbie Inquiry and also the Munro Review of Child Protection[xiii]. It is particularly likely to surface when, and if, practitioners feel under more pressure than usual or when there are weaknesses in the quality of case oversight.

**Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.34 Child protection inevitably involves working with uncertainties and making difficult decisions and complex judgements on the basis of incomplete information in rapidly evolving, often hostile and highly stressful contexts. The single most important factor in minimising errors is to admit that you might be wrong (Munro 1999[xiv]) and be willing, encouraged and supported to challenge, and where necessary revise views throughout the period of any intervention. The ease with which different people feel that they can

[21] http://wiltshirescb.org.uk/wp-content/uploads/2016/10/WSCB_Escalation_Policy.pdf

challenge and/or be challenged reflects the culture of the organisation and the degree to which the interests of children are at the forefront of multi-agency work.

3.35 Where there are professional disputes regarding a child's circumstances there are dangers that professionals can become polarized and alliances form between some of those professionals and the parents against the multi-agency group. This can look and feel like support to vulnerable and disadvantaged people, but can mask collusion and active processes to divide professionals.

| **Finding 3: Appropriate routine professional challenge and the use of escalation processes is insufficiently embedded in the multi-agency network in Wiltshire, leaving differences in professional opinion unaddressed and causing feelings of "learned helplessness" which in turn makes resolution less likely. This undermines the safety and wellbeing of children and does not support action to address concerns.** |
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| There were differences of views about the family and Mother's approach that were expressed at the time but never escalated beyond an initial challenge. The absence of reflection or analysis as a practice norm at the time meant that there was no place to explore and therefore understand these different views in the context of the children's needs or whether Mother's approach was really an active strategy to divide people. |
| **Questions for the Board**<br>• How confident is the Board that practitioners and managers across the county are aware of and understand the WSCB Escalation Policy?<br>• What more, if anything, could be done to improve the reach of the WSCB?<br>• How might the WSCB and its member agencies develop the kind of organisational culture across Wiltshire that welcomes and facilitates professional debate and difference?<br>• How might the WSCB monitor the effectiveness of culture change? |

**Finding 4: There is a tendency for professionals to uncritically accept what adults tell them about their children in the mistaken belief that this is "working in partnership", resulting in an inaccurate description of children's needs and circumstances which are left unaddressed as a result.**

**Introduction**

3.36 It is essential that all professionals working with children and their families do so in a respectful and open way. This is the cornerstone of partnership practice as embedded in the Children Act 1989[xv] and subsequent guidance and legislation. Partnership means

developing effective relationships[xvi] with families, communicating effectively and clearly and ensuring fairness. Professionals take these responsibilities seriously and there is good evidence that working in this way improves outcomes for children. It is important not to just take what parents or carers say at face value when they are asked about the possible abuse of children.

3.37 The Munro Review[xvii] commented that adults in this situation have a number of motives for not always providing a full picture of their or their children's circumstances. The task of professionals where there are concerns about children is to remain in a position of "respectful uncertainty" and display "healthy scepticism". This means routinely checking the validity of information provided by parents/adults by cross referencing and triangulating with other sources and testing out the level of parental care and concern for children and the extent to which parents feel a sense of responsibility for their children and their well-being. This did not always happen for the five siblings under review.

**How did the issue manifest itself in this case?**

3.38 There were many occasions throughout the period under review when both Mother and Mr W made assertions about the children and what they had done as a consequence which were recorded as fact without checking. The issue of Sibling 2's nit infestation was discussed with Mother by the school on many occasions and Mother was given considerable support to take action. Mother reported that she had taken Sibling 2 to the GP who had told her that Sibling 2 was allergic to the nit treatment and she cited this as the reason why the problem was so acute and why she could do nothing about it. This was reported to the social worker during the assessment in September 2014 and discussed during the CIN meetings. Mother's account was never cross-checked with the GP; none of the children actually saw the GP during this time. This meant that Mother's lack of action to address this serious issue was never addressed.

3.39 Mother also provided information about the YP1 who was living in the family home. She said, during the assessment process, that the police had checked his circumstances. This was not true. Mother explained why YP1 was living at the family home and this was accepted without comment. It remains unclear what YP1's circumstances were because Mother's explanation was accepted without comment or critique. This meant that vulnerabilities were not known, he was never spoken to and his wellbeing was not assured.

3.40 During the first CIN meeting in September 2014 Mother was asked to outline the circumstances of each child. Her report of the children contrasted with that of the professional's present but this was not commented upon at the time and there was no analysis of what the gap between Mother's self-report and professional knowledge might mean for the outcomes for each child. For example, during this meeting the issue of the possible young caring responsibilities of Sibling 5 were discussed and Mother reported that Sibling 5 was happy to take these on and that there were benefits for her regarding this.

This was not the view of all of the professionals and the lack of discussion meant that no view was formed within the CIN process about this or action agreed.

**How do we know it is an underlying issue and not something unique to this case?**

3.41 Through conversations with the professionals and Case Group it became clear that a norm has developed of recording what parents say without professional critique or analysis. The parents view then becomes the accepted view without challenge.

**How prevalent and widespread is it?**

3.42 Because this has been verified by practitioners involved in the case as a practice norm it is likely to be occurring regularly and to be a feature of any group meetings where parents are present and the nature of abusive behaviour is not clear. Other factors will make it more or less likely, such as the quality of case supervision, the organisational culture (see Finding 3), the knowledge and experience of practitioners and the degree to which they feel under pressure to move the process forward.

3.43 The tendency for professionals to give too much credence to what parents say, because this feels like working in partnership, is an issue that has been noted nationally in the SCR biennial/triennial reviews (Brandon et al 2016[xviii]) and was something raised in the Munro Review of Child Protection 2011[xix]. Munro's latest work, Improving Child Safety[xx] highlights the central importance of professional deliberation in order to determine the nature of the issue and the kind of intervention that stands the best chance of addressing it effectively.

**Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.44 It is much safer for children, young people and their families if challenge of what is reported by parents is built into processes such as supervision and decision making, but also into cultural expectations which recognise that asking questions and seeking explanation from parents is something to be valued. A high reliance by professionals on self-report by parents brings with it significant risks of proceeding on false information.

3.45 Arrangements put in place to recognise when there is insufficient challenge, and to increase the value given to challenge, are in the interests of families and professionals. Such arrangements can include ensuring time for in depth supervision, ensuring an independent uninvolved voice at key decision-making meetings, managers modelling that challenge is acceptable, and showing how it can be done in a constructive way so that workers have more confidence in challenging parents.

| **Finding 4: There is a tendency for professionals to uncritically accept what adults tell them about their children in the mistaken belief that this is "working in partnership", resulting in an inaccurate description of children's needs and circumstances which are left unaddressed as a result** |
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| This finding highlights what happens when the requirement to 'work' with families loses its meaning. This is not to underestimate how difficult it is for a professional to build a relationship with a parent or anyone in a caring role that is supportive and appropriately challenging, particularly when that parent or carer is resistant to professional intervention in the first place. |
| **Questions for the Board**<br>• Is there a collective view at the Board about the prevalence of this issue and the scale of change needed around challenge with families?<br>• Is enough known about the perspectives of the workforce on this issue? Is there a view that to challenge parents is to be judgemental?<br>• How could the Board promote a culture where professionals are supported to be challenging when necessary?<br>• Is there clarity about when assessments can and should be shared with multi-agency colleagues? |

**Finding 5: The lack of an effective practice framework for working with neglect in Wiltshire has left professionals deskilled in their response, and inconsistent in how they explicitly name child and adolescent "neglect".**

**Introduction**

3.46 It is essential that professionals are equipped to recognise, assess and intervene effectively regarding child neglect. This requires a focus on the quality of care provided across the developmental domains of physical care, health, education, supervision and safety as well as emotional care, including the development of a moral compass and pro-social behaviour.

3.47 Gaps in the care provided in all these areas should be considered as "global" neglect and requiring serious attention. Understanding which areas of a young person's life are most affected provides both a pathway to appropriate interventions and protective activities, and may also help to understand current complex and difficult behaviour.

3.48 Alongside a detailed understanding of the quality of care across the developmental domains, it is also essential that professionals assess parental attitude. Neglect is often assumed to be an act of omission with parents /caregivers struggling to provide effective care because of their own impoverished and deprived circumstances. This is very often the

case and this knowledge provides a pathway to appropriate support and intervention. However, for some parents or caregivers neglect is an act of commission; they take no responsibility for the quality of care they provide and are often hostile or dismissive to advice or interventions. These parents do not agree with professionals' concerns and do not engage in services designed to improve their children's circumstances. These render those services ineffective and require robust challenge.

3.49 Underlying all of this is the importance of trying to establish why parents and caregivers neglect their children and, having established this, attention needs to focus on addressing those primal issues, rather than only dealing with the consequences such as addressing poor physical living standards. If the primary cause is not assessed and addressed, the pattern will continue. Finally, it is important that professionals consider what other abuse runs alongside the neglect of children. There is now a clearly established link between child neglect and the possibility of intra-familial sexual abuse and sexual exploitation. Where children's needs are not addressed they are vulnerable to these kinds of risks.

**How did the issue manifest itself in this case?**

3.50 There had been long term concerns regarding the neglect of these children spanning many years and from when the younger children were born. The initial strategy meeting noted that there were likely significant concerns about neglect. This was confirmed when the home was visited as part of the initial child protection inquiries. However, an assessment or an analysis of child neglect was not included in either the subsequent child protection inquiries or the full assessment that was completed at this time. Over time the overall concept of child neglect was never explicitly discussed or recorded, despite the myriad of examples that these children were being neglected.

3.51 There appeared to be a reluctance across the professional network to name "neglect" as an issue. It was striking that in the CIN meeting held in December 2014, the wellbeing of Sibling 4 was said to have improved considerably as a result of moving to his Father's care some 8 weeks earlier. There was no discussion about why this might be the case, and what the implications were for the care of the other four siblings.

3.52 In October 2014 SW3 visited the family home and found it to be in a very poor state of repair and the children were described as looking uncared for. There was evidence of young people using the home for a party and young people asleep on the couch. Concern was expressed, but this was not described as part of a pattern of neglectful care for these children and no action was taken.

3.53 Over time each school attended by the children had concerns about the quality of care they were receiving and the impact that this was having on both their ability to engage fully with school, and their overall wellbeing. The schools were also aware that Mother was often

dismissive of the concerns and their impact on the children and took none of the advice given. This was all important information as a picture of neglect, but when these issues were shared with CSC the focus was on the presenting problem in the main, as opposed to a holistic picture and analysis of neglect.

3.54 Finally, both Sibling 4 and 5 were said to have "young caring" responsibilities and there was a proposal that a referral be made to a young carers group. There was never any discussion or analysis of whether these responsibilities were appropriate, and whether they indicated concern about the neglect that Sibling 4 and 5 were experiencing.

**Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.55 There is significant recognition across practice, policy and research networks of the serious negative impact of long term neglect on children's wellbeing and outcomes across the developmental lifespan into their future as adults. If there are ineffective identification processes, assessment frameworks, tools and interventions to address neglect, it will not be possible to meet the needs of children in the short or medium term and professionals will not be able to break the long cycle of neglect that is often seen from generation to generation.

| **Finding 5: The lack of an effective practice framework for working with neglect in Wiltshire has left professionals deskilled in their response and inconsistent in how they explicitly name child and adolescent "neglect"** |
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| Neglect is arguably the most difficult kind of abuse to identify, particularly over time if practitioners are not in the habit of working with the kind of historical as well as current data that might enable patterns to be detected. Because professionals tend to over-focus on symptoms of physical care being less than good – symptoms such as dirty clothing, nits etc. – neglect is also susceptible to being explained away as a consequence of poverty. Sometimes this will be the case and sometimes not. In order to identify where it is not, the evidence building as part of any assessment needs to be transparent and systematic; practitioners need to feel confident and supported in naming neglect as neglect where they deem it to be the case. |
| **Questions for the Board**<br>• How confident are Board members that practitioners tasked with identifying, assessing and addressing neglect have the necessary skills and tools to do so?<br>• What work has the Board done to evaluate the local response to neglect?<br>• What work does the Board need to undertake to help partner agencies improve practice when working with neglect?<br>• How will the Board know they have been successful? |

**Finding 6: Although there have been changes to the way in which Child in Need processes are delivered in Wiltshire, there appears to be continued evidence that they lack a multi-agency approach and the rigour and focus seen in child protection processes is missing, with the result that there is insufficient analysis of children's needs.**

**Introduction**

3.56 The Children Act 198[xxi] defines Children in Need (CIN) as those children whose vulnerability is such that they are unlikely to reach or maintain their health and development without the provision of services to them and their families. This is a serious issue for all children. Good quality multi-agency assessments that provide a clear analysis of the child's needs are an essential part of the Child in Need Process; once an assessment has been completed it is expected that a child focused plan will be formulated which addresses those needs and outlines the expected outcomes for the child/ren, services to be provided and the reviewing mechanisms identified.

3.57 These are important formal processes. The aim is to develop plans which improve children's health and development and which address any challenges to this. CIN plans and meetings were always intended to be multi-agency in approach, amalgamating the analysis of all agencies and developing a plan which addresses the shared concerns.

3.58 Child in Need meetings are intended to be child centred and to be a forum where children are able to contribute and share their perspectives in a supported way. CIN meetings should also fully involve parents or any adult who has a parental role. This involvement needs to be supported; however, boundaries need to be set whereby there are expectations on the behaviour of all present. It is also important to think carefully about whether there are a small number of parents/parent figures who should be asked to contribute to the CIN process in different ways because there are concerns about the way in which they will either disrupt the meetings or use their attendance to impose power and control over adults/children or as a way to groom children. This needs careful thought.

3.59 Clear standards and expectations have been set regarding the process of child protection processes and plans. Although a clear framework exists for best practice in CIN, research suggests that child protection processes can take precedence, particularly at times of high workloads; assessments are single agency and lack analysis; there are unclear goals and outcomes and there are unclear review processes. This was the case here.

**How did the issue manifest itself in this case?**

3.60 It was agreed in September 2014 that the five siblings would have CIN plans and that these would need to be "robust" because of the complexity of their circumstances. From the start the individual needs of each child were not clearly delineated, in part because the first

assessment was so adult focused. This could have been addressed at the first CIN meeting when the CIN plan was discussed, but again this did not outline the particular circumstances of each child, nor did it provide an analysis of the key issues that the plan was supposed to address. Concerns about neglect, for example, were never articulated and nor was the risk of sexual abuse. These were acknowledged as central concerns at the beginning of the first CIN meeting and never raised again.

3.61 Plans were agreed at this meeting including sorting out a school place for Sibling 1, addressing the chronic nits for Sibling 2 through health action, a referral to a young carers project and a referral for 'keep safe' work. These actions were never taken forward and never reviewed as missing. The pattern that developed in the meetings was that there would be general discussions about the "here and now" which were descriptive, rather than analytical and depended on who was present at the meeting. The actions agreed would often drift or get lost and this was not noted because they were not reviewed. In effect, there was no CIN plan - just meetings that discussed the children in general terms. They were not outcome focused and the children's own perspective was not apparent.

3.62 The lack of an overall "robust" plan for these children was not noted, and although the issue of drift was raised by multi-agency partners and discussed in January 2015 this led to no action. This lack of focus based on children's needs meant that the work of the multi-agency network was incident focused and issues were addressed as they arose. The absence of goals or outcomes meant that by June 2015, CSC started discussing the need for the CIN plan to be closed. This was in the absence of any real progress.

3.63 Although CIN plans, based on good assessments, are meant to be multi-agency in approach, for these five siblings it was striking the extent to which those agencies who know the children best, were often unaware of or not invited to attend relevant meetings.

3.64 Mr W was invited to all the CIN meetings and there was no discussion about whether this was appropriate in the context of grooming and the use of adult authority discussed in Finding1. Further thought should have been given to this and whether Mr W's attendance would prevent there being an overall discussion of the issue of sexual offending. It was clear that given the unknown risks in this case that it should have been managed at a child protection level. However, having agreed a CIN plan, it should have been focused on a good analytical understanding of each child's needs and circumstances, goals should have been set to address these needs and these should have been reviewed over time with action where these goals were not progressed. This did not happen.

**How do we know it is an underlying issue and not something unique to this case?**

3.65 The Review Team and Case group suggested that it had been helpful to reflect on how CIN processes were operating in Wiltshire. They agreed that although there had been changes

locally, the issues of the lack of analysis of children's circumstances within the meetings and variable review of goals set resonated with their experiences in other cases.

**Why does it matter? What are the implications for the reliability of the multiagency child protection system?**

3.66 CIN processes are a core part of the safeguarding continuum. It is essential that they are delivered in effective ways if children are to be safeguarded, their needs met and outcomes improved. If these processes are not effective there is likely to be repeat referrals.

| **Finding 6: Although there have been changes to the way in which Child in Need processes are delivered in Wiltshire there appears to be continued evidence that they lack the rigour and focus seen in child protection processes, with the result that there is insufficient analysis of children's needs and plans which are incident-led and not focused on addressing the concerns they were tasked with.** |
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| Child in Need meetings are an important part of the multi-agency protective system, ensuring that children whose development and wellbeing is likely to be impaired receive services which address clearly those needs. If they lack rigour or focus children's outcomes are likely be compromised. |
| **Questions for the Board**<br>• Does the Board have sufficient knowledge of how well Child in Need processes are working locally?<br>• Does the Board know the extent to which CIN processes have been embedded in all agencies practice and are truly multi-agency in approach?<br>• Are the Board aware of factors that prevent CIN processes from being multi-agency and what can they do to address this?<br>• Are the Board aware that there is confusion about whether the single assessment, which forms the basis of the CIN plan, are not always shared with agencies?<br>• How will the Board be able to measure any improvements in practice and outcomes for children? |

## 4 Final Thoughts or Conclusion

4.1 The Review of the circumstances of these five siblings has raised concerns regarding the collective and cumulative impact that resource pressures can have on the delivery of services. These pressures led here to poor assessments, drift and delay in implementing plans, significantly delayed criminal processes and a lack of a consistent approach to the link between the children's health needs caused by neglect and the child in need (CIN) processes. It is important that the Safeguarding Children Board is confident that they are made aware of these pressures when they occur and the possible implications for the wellbeing of children.

[i] Department for Education (2015) Working Together to Safeguard Children

[ii] Calder, M (2009) Sexual Abuse Assessments: Russel House Publishing

[iii] DfE (2015) Working Together to Safeguard Children: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[iv] Finkelhor, D. Childhood Victimization: Violence, Crime and Abuse in the Lives of Young People. Oxford University Press, 2008.

[v] Ibid

[vi] The Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings. The Home Office and The Department of Health,1992. Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, Including Children. The Crown Prosecution Service, 2001.

[vii] Horvath, M.A.H., Davidson, J.C., Grove-Hills, J., Gekoski, A. and Choak, C. (2014). "It's a lonely journey" A Rapid Evidence Assessment on intrafamilial child sexual abuse. London: Office of the Children's Commissioner

[viii] Alnock, D and Miller, P (2013) No one noticed, no one heard: A study of disclosures of childhood abuse: NSPCC. https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/no-one-noticed-no-one-heard

[ix] Reder, P and Duncan, S (1999) Lost Innocents: A Follow-up Study of Fatal Child Abuse: Routledge

[x] Peterson, C., Maier, S.F., & Seligman, M.E. (1995). Learned Helplessness: A Theory for the Age of Personal Control. New York: Oxford University Press.

[xi] Reder, P and Duncan, S (1999) Lost Innocents: A Follow-up Study of Fatal Child Abuse: Routledge

[xii] Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A. and Sorensen, P. (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014: final report. [London]: Department for Education.

[xiii] Munro, E. (2010), The Munro Review of Child Protection – Part One: A Systems Analysis, London: Department for Education.

[xiv] Munro, E. (1999) 'Common errors of reasoning in child protection work', Child abuse and neglect, 23, 8, 745–758.

[xv] http://www.legislation.gov.uk/ukpga/1989/41/contents

[xvi] Munro, E. (2010), The Munro Review of Child Protection – Part One: A Systems Analysis, London: Department for Education.

[xvii] Munro, E. (2010), The Munro Review of Child Protection – Part One: A Systems Analysis, London: Department for Education.

[xviii] Munro, E. (2010), The Munro Review of Child Protection – Part One: A Systems Analysis, London: Department for Education.

[xix] Munro, E. (2011), The Munro Review of Child Protection –A Child Centred System, London: Department for Education.

[xx] Munro et al, (2016) Improving Child Safety: deliberation, judgement and empirical research

[xxi] http://www.legislation.gov.uk/ukpga/1989/41/contents