Local Child Safeguarding Practice Review Report Child G

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Date: October 2021

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1. Introduction and background to the review

1.1 Background to the Review

When Child G was 16 years old, she disclosed to Police that she was the victim of sexual abuse, including rape by her brother Sibling 1, now aged 25 years, over a five-year period in the family home.

1.2 The National Panel determined that the case met the criteria for a Child Safeguarding Practice Reviews on the basis that:

- A child has suffered significant harm
- Abuse and/or neglect were a contributory factor

Working Together to Safeguard Children 2018, expects the following of reviews:

- *Improvements needed to safeguard the welfare of children*
- *Recurrent themes in safeguarding practice*
- *Concerns regarding two or more agencies working together to safeguard children*
- *Concerns about a single agency's ability to safeguard children*

1.2 Review Process and Methodology

The Child Safeguarding Practice Review has used aspects of the Welsh Model to build upon the learning already identified in the Rapid Review. The structure has been used to carry out the following:

- Identify key events chronologies and IMRs from agencies
- Conduct Interviews with key personnel to explore good practice, missed opportunities and learning
- Establish a separate Child Safeguarding Practice Review Panel consisting of senior managers from relevant agencies
- Appointment of an Independent Author who will Chair the Panel and write the overview report

The Child Safeguarding Practice Review has built upon the learning already identified in the Rapid Review, consisting of key events chronologies and Single Agency Reflective Analysis Reports from agencies and two practitioners' event to explore good practice, missed opportunities and learning.

The review has included:

- A review of the records relating to Child G and her family and the provision of Single Agency Reflective Analysis Reports and chronologies by each of the agencies that were involved with the family.
- Meetings with the authors of these agency reports led by the Reviewer.
- Two Practitioner events led by the Reviewer, to enable those involved in the case to share their experiences; to gain broader learning and ideas for improving practice and the learning of the agencies from feedback from practitioners; to understand why individuals acted as they did and what was influencing their practice.
- A virtual meeting with Child G and communication with her.
- A virtual meeting with Sibling 1, her brother, who was the abuser.
- A brief report by the independent reviewer, focusing on learning with:
    - A conclusion as to whether, as a result of learning from this case, any changes are required to practice, policy or procedures by individual or collective agencies.
    - Recommendations demonstrating responses to the Case and System Issues identified.

2. The Child Safeguarding Practice Review's Scope and Focus

2.1 TERMS OF REFERENCE

The review was asked to investigate:

- The degree to which professional curiosity and authoritative enquiry were exercised when responding to Child G's concerning behaviours.
- The degree to which professional curiosity and authoritative enquiry were exercised when considering and responding to Child G's gender identity.
- The extent to which holistic assessments of the family were undertaken particularly taking account of working with a family with additional learning needs.
- Quality of risk assessments carried out in relation to Sibling 1 that took account of his mental health, learning needs and the risk he potentially posed to children and vulnerable adults he had access to.
- Whether the parents were risk-assessed and supported to both care for Sibling 1 and keep Child G safe.
- How agencies worked together and shared information about Sibling 1's risk and Child G's safety.

2.2 SCOPE OF THE REVIEW

The scope of the review is the period from 1 October 2014, which is the date when Sibling 1 then aged 19 years) first came to the attention of the Police for possible inappropriate contact with children, until 3 August 2019 - when Child G made the disclosure of sexual abuse by Sibling 1.

Child G is being used in the review and the feminine gender is used at her request. However, it is of note that it appears that Child G is now identifying as male.

2.3 AGENCIES CONTRIBUTING TO THE REVIEW

- Children's Services (MASH, CFP, Children's Social Care)
- Adult Services, Learning Disability Team
- Thames Valley Police
- CNWL (School Nursing, CAMHS, Adult Mental Health Service)
- Child G's school during the period
- Young Carers
- Q:alliance (young person's LGBTQ Service)
- Family GP
- Sibling 1's Adult Day Centre

3 Summary of the Learning from the Review

There was some good and effective practice evidenced in this case and Child G was provided with a range of support from several different agencies. Her needs were identified, particularly by her school, when her behaviour and focus on her schoolwork declined. A range of support was put in place.

3.1 However, there was a lack of diligent enquiry and investigation even when opportunities arose to ask more questions and to exercise a greater degree of professional curiosity in relation to changes in Child G's behaviour. A great deal of help was provided to Child G but only as response to Child G's

immediate presentation without further questioning about the cause of her behaviour – it was thought that enough was known.

There was one highly significant event in 2014 when a member of the family raised concerns to Police about the possibility of sexual contact taking place between Child G and Sibling 1 in the home. This allegation was not subject to a Section 47 enquiry or investigated jointly with the Police as is required within the local policy and procedures. A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm. In this situation, the Local Authority and Police could have initiated a joint enquiry with the Police focusing on a criminal investigation. As a result, key forensic evidence was not retrieved nor analysed, and key professionals were not brought together to share how much they knew. A potential crime had been committed against Child G and there was no Police investigation carried out to establish if any offences had been committed. It was a missed opportunity to investigate a potential serious offence.

3.2 When Child G started questioning her sexuality and gender identity professionals did their best to support her and to ensure she did not strap her breasts or take hormones. It would have been difficult to foresee that perhaps this change in her view of her identity could be linked to the sexual abuse she was suffering at home from her brother, Sibling 1. It was an additional factor which perhaps should have been explored further with her.

3.3 Most of the intervention with the family was by single agencies. Even when Children's Social Care was involved and completed assessments, these did not lead to any joint planned work with Child G or the family. It is significant that there were no joint professional meetings to discuss what everyone knew about the different members of the family and about the problematic family culture they shared, and which was known to a variety of different agencies. There was violence and threatening behaviour within the household from Sibling 1. Father and step-mother stated that they were trying to set boundaries to Sibling 1's behaviour but the evidence is that they did not succeed in doing so. This left the other children vulnerable and feeling insecure in the household.

3.4 There was a lack of risk assessment by agencies of Sibling 1's sexual offending behaviour. His association with young girls was not taken seriously enough by the adult social care service and nor was any link made to potential risk to his siblings at home. The potential risks from Sibling 1's sexualised behaviour outside the home and on-line viewing of sexually inappropriate websites were not fully considered in relation to risks to his siblings, including Child G, living in the household. Even when these risks were identified a very high reliance was placed on the father and stepmother to supervise Sibling 1's contact with the children.

3.5 In addition, Police responses to Sibling 1's behaviour were not well coordinated or linked together. Several different sections of the Police service were involved, and information was not always shared across the whole local Police service. In addition, Police responses were not always appropriate and appear to have taken overdue account of his autism. When Sibling 1 seriously physically assaulted his stepmother, this was dealt with appropriately under the Domestic Abuse Policy guidelines. However, Sibling 1 only received a caution, and the risk assessment was only graded as "standard" which did not accurately reflect the level of injury - nose bleeding and bruising to face and arms - and accounts from those present that Sibling 1 intentionally gouged at the eye sockets of his stepmother. This indicated that Sibling 1 had the potential to cause serious harm, and this has been regarded as an opportunity missed to provide his stepmother with advice and support from a specialist department.

3.6 Children's Social Care did assess the family on three occasions, but these were brief, time-limited interventions which lacked rigour. The parents' reassurances about their capacity to manage the risks from Sibling 1, were too readily accepted and there was no thorough testing of their ability to protect the children and to manage Sibling 1.

3.7 Many agencies were involved to support Child G and to work with Sibling 1 in relation to his additional needs and sexual offending but there was a lack of joined up working. There were many isolated interventions with no one leading a joint approach to managing the concerns.

There was little evidence that professionals understood the prevalence of the national research on child sexual abuse particularly within families. It appeared to seem unlikely and even unthinkable to them that there was sexual abuse occurring within the family. There is no evidence, apart from the assessment completed in 2014, of any consideration or discussion about whether there could be child sexual abuse occurring within the family. This is surprising given how prolific Sibling 1 was in his sexually inappropriate behaviours towards female children and some adults outside the family. There could have been a more family-based approach working with the case, but it is not clear that this would have prevented or stopped the abuse of Child G. It is highly likely that several family members were aware that this was happening, but it was a family with "secrets" and a coercive and, at times, violent culture driven by Sibling 1 and supported by his father who did not appear to challenge what was happening.

4 Brief Family Background and History of the Case

4.1 The Family

The family – Child G's father and birth mother separated shortly after Child G's birth in 2003. Police reported in 2001 that the house was unclean and there was little food for the children. The four children Sibling 1, the eldest, his brother Sibling 3 and his two sisters - Sibling 2 and Child G remained in the care of their mother after the separation. In June 2005, Sibling 1 was seen to have a bruise which he disclosed had been caused by his mother hitting him with a belt. All four children came into LA care before moving to the care of their father who put himself forward to look after them. In 2006 birth mother was convicted of assaulting Sibling 1 and received a custodial sentence.

From 2005, all the children were living with father and subsequently their stepmother and her daughter.

In 2014, Child G was living with her father and stepmother as well as her step-sibling - b 1996, and her siblings: Sibling 1 (brother - b 1995), Sibling 2 (sister- b 1997) and Sibling 3 (brother – b 2000).

4.2 Child G (b2003)

Child G, aged 16 years at the time of her disclosure in 2019, was the victim of sexual abuse, including rape by her brother Sibling 1, now aged 25 years, over a five-year period in the family home. Child G has an older sister and another brother as well as Sibling 1; she was also living in the household with a step-sibling. Child G does not have contact now with her birth mother due to previous neglect and was in the care of her father and stepmother. Both father and stepmother also appear to have additional learning needs according to the Adult Social Care records. Since she disclosed her abuse, she has suffered significant mental health problems and been treated in hospital and in the community.

4.3 Sibling 1

Sibling 1 has a diagnosis of autism and learning difficulties and has a history of inappropriate sexual contact with children and inappropriate use of the internet. At the time of the disclosure Sibling 1 was under investigation for attempting to groom a child online and was known to have accessed websites to watch

brother-sister pornography. His father and stepmother were the main carers for Sibling 1. Whilst known to be at risk of committing sexual offences and having been investigated for these over a lengthy period, Sibling 1 continued to have access to Child G in the family home. Sibling 1 also worked in a farm visited by children and attended a day centre for vulnerable adults. Sibling 1 has been convicted of the sexual offences against Child G and he is currently serving a prison sentence.

5 Summary and Analysis of agency and professional involvement with Child G's Family

5.1 There were many different agencies involved with Child G and her family during the review period. However, there was very limited coordinating activity or evidence of fully informed and shared responses to identify, assess and meet her needs.

5.2 There are some examples of positive efforts and interventions to support Child G such as referral to Young Carers, additional support at school and referral for counselling. However, these interventions were not targeted at the root cause of her problems which in hindsight we know was the sexual abuse which she suffered within the family for over five years. The interventions were reactive and not holistic in bringing together all the information about her circumstances.

5.3 Child G's school implemented a range of support for her – school counsellors, CAMHS, School Nurse, Young Carers and Q:alliance were all involved. The school engaged proactively with universal and targeted service including the MASH. Child G related well to the school's pastoral staff and was able to share many worries about her family's circumstances. It is clear that the staff were child focused. They were responsive to Child G's wishes and feelings though they did not remain sufficiently curious about possible wider causes for Child G's distress – even when she had spoken about her brother, Sibling 1's sexualised behaviour and offending.

5.4 School Nurse
Child G had contact with the School Nurse in May 2019 at her school.
Child G engaged well with School Nursing, was very talkative, maintaining good eye contact throughout. She was dressed appropriately. She discussed her wish to identify herself as male. She spoke about her father's cardiac condition and also that she has a lot of stress in her life as her older brother was being investigated by police for possible child pornography offences. Child G admitted to sometimes having difficulty sleeping, which was discussed, and advice given. She admitted to struggling with her anger.

It was agreed that Child G would see the School Nurse again about her anger problems. It was documented that no safeguarding concerns were identified at the meeting by School Nursing, so it was agreed to maintain confidentiality from her parents at Child G's request.

5.5 The **Young Carers** service provided considerable support and listening opportunities for Child G over a very long period. Child G spoke about her worries and regular conversations took place with school as well. **Q:alliance** offered social opportunities to Child G as well as an opportunity to share her queries about her sexual identity.

5.6 Children's Social Care (CSC)
Children's Social Care had had previous involvement with the family dating back to 1998. As stated above the children were briefly in care in 2005 when their birth mother was convicted of assaulting Sibling 1. In 2007 Sibling 1 was referred following involvement in sexually inappropriate behaviour at school. In 2008 brother, Sibling 3 was referred after engaging in sexually inappropriate behaviour with another boy at school. In 2012, an anonymous referral alleged drug misuse and physical chastisement. In 2013, Sibling 1

alleged he had been assaulted by his stepmother and sister. In 2014 step-sibling alleged that she had been assaulted by Sibling 1. Checks were undertaken and the family spoken to but there was no further action.

In October 2014, Police informed Children's Social Care that a call had been received from the adult foster sister of stepmother. She reported that stepmother had shared with her that she was concerned that she had seen blood in the bed of her stepson, Sibling 1, and in Child G's underwear. At this time Child G was only 11 years old. Children's Social Care appears to have decided that the referral did not meet the threshold for a Section 47 Strategy Discussion and would be progressed as a section 17, Children and Family Assessment. It is noted that the "Section 47 worker" would be involved. The recording is unclear, with the assessment completed being described as a Child and Family Assessment.

The local Procedures state that "*if there is reasonable cause to suspect a child is suffering, or is likely to suffer Significant Harm, Children's Social Care should convene a Strategy Discussion. This may take place following a referral or at any other time if concerns about significant harm emerge".* In this case, this did not occur even though there was evidence that Child G was likely to be suffering harm and the particular case of possible sexual offence is specifically mentioned. This was contrary to the Milton Keynes Inter-Agency Safeguarding Children Procedures which also clearly specify that there should be a joint investigation with the Police.

Procedure item 6.11 *A joint investigation must always be initiated whenever there is an allegation or reasonable suspicion that one of the circumstances below applies, regardless of the likelihood of a prosecution:*
- A sexual offence committed against a child by a child or adult but excluding "stranger abuse".

This procedure was not followed and there was no joint Strategy Discussion between Children's Social Care and the Police. According to the Children's Social Care records this action was agreed with a Police Officer though this is not confirmed by the Police Agency Report. Therefore, Children's Social Care carried out a home visit and spoke to Child G who denied that anything had occurred as did Sibling 1. Sibling 2 said that she believed Sibling 1 had sexually abused Child G, as she had seen them spending time alone together and had told her stepmother she was worried. There is little exploration in the assessment completed of why this sibling held this view and it appears to have been discounted.

This was a missed opportunity to safeguard Child G through a joint investigative process not least because there was potential forensic evidence which could have been included in a Police investigation of a potential crime and which could have been tested to establish the source of the blood. There is research-based evidence that most children do not disclose sexual abuse within the family and the expectation that Child G would disclose was not considered against that learning from other cases.

In 2015, a second children's assessment based on one visit and a conversation with Child G, was completed following a referral about brother, Sibling 3 who was alleged to have kissed a 10-year-old boy and showed him pornographic material on his mobile phone. He was spoken to and cautioned by Police. Child G and Sibling 3 were to be referred to Children and Family Practices for protective behaviours work. Sibling 3 was offered counselling but there is no record of Child G receiving any sessions. This was apparently seen as an isolated incident and the assessment was narrowly focused with Sibling 1 not even being spoken to despite previous concerns about sexually inappropriate behaviour and the 2014 allegation.

In 2017, a further Children's Social Care assessment was undertaken after Police had reported to Children's Social Care that Sibling 1 had been arrested for inappropriately talking to a child on social media and was apparently grooming her. Father maintained that he did not feel Sibling 1 posed a risk to his siblings. Child

G was seen and was very positive about her relationship with her father and stepmother. School shared concerns in relation to Child G's uncertainty about her identity and sexuality and about her possible self-harming because Child G often seemed to pick scabs on her face and there was questioning of her parents' capacity to cope with a number of children with complex needs and their problems with these. Both parents were recorded as suffering from depression and anxiety and stepmother had osteoarthritis and diabetes. The case transferred from Children's Social Care and was open to Children and Families Practice till March 2018. The Social Worker felt that the parents were open and would protect Child G and undertook to supervise Sibling 1 with his siblings and this assessment was accepted and signed off.

5.7 Police

The Police had had some involvement with the family since 1999 including domestic incidents and adult protection as well as the disclosure made by Child G in 2019.

From 2011, Sibling 1 came to Police attention on 12 occasions in regard to his concerning behaviour towards young females. The behaviour escalated from following young girls, taking photographs to contacting them online. The Police failed to identify fully the threat posed by Sibling 1 and on occasion, for example his autism was used to excuse his behaviour rather than to understand what impact, if any, it had.

The referral made in October 2014 by Police to Children's Social Care in relation to stepmother's foster sister information about blood in Sibling 1's bed and on Child G's underwear was, as stated above, not jointly investigated. This was not challenged by Police at the time. If the MASH Police representative had challenged the Children's Social Care decision not to have a section 47 Strategy Discussion, this would have provided an opportunity for agencies to have an open discussion and to achieve a fully multi-agency professional approach towards addressing the concerns by Child G which was never achieved in this case.

There were several violent incidents in the household and with the children present. In July 2015, Sibling 1 seriously assaulted his stepmother and Police were involved. Sibling 1 had a knife and made threats to stab family members if the Police tried to get into the property. This was described as an unprovoked and vicious assault. In September 2015, Sibling 1 called Police reporting that he had been assaulted by his father and that his step-sibling had self-harmed by cutting. In January 2016, the step-sibling reported that she had been physically assaulted by Sibling 1. Children's Social Care was informed of this as Child G and Sibling 3 were present, but they were not spoken to which was a missed opportunity to gather more information.

There were also several concerns about Sibling 1's behaviour in the community. In April 2016, Sibling 1 was reported as being on a motorbike outside a school filming children. Sibling 1 was given "words of advice". This was seen as typical behaviour for Sibling 1 as he had a diagnosis of autism and safeguarding was not considered for the threat Sibling 1 posed to children. This hanging around school by Sibling 1 was apparently a regular behaviour. Appropriate links were not made to Sibling 1's overall pattern of inappropriate behaviour. In June 2016, a 10-year-old girl reported receiving over-friendly messages from Sibling 1. There was no Police action, with Sibling 1 saying that because he is autistic, he found it easier to socialise with people of a younger age. Children's Social Care was informed. These were missed opportunities to address Sibling 1's potentially harmful behaviours with an undertone of sexual behaviour. In 2017, stepmother told a third party that Sibling 1 had texted a 13-year-old female friend of Child G asking her to be his girlfriend. Sibling 1 was not spoken to, which should have happened to remind him that this behaviour was inappropriate. This inaction by Police seems to imply that there was a minimisation of Sibling 1's behaviour and failure to identify the emerging worrying pattern of behaviour

because of his vulnerability as someone with autism.

From 2017 to 2019, Police investigated various public reports about Sibling 1's inappropriate use of the internet. Referrals were made by Police to Adult Social Care and Children's Social Care. He was arrested, he admitted the offence against a 12-year-old, stated he knew it was wrong and admitted that children sexually arouse him. For the offence he received a conditional caution and the action taken did not appear to stop Sibling 1's behaviour. Sibling 1 had been having inappropriate conversations with a 10-year-old girl, using an account purporting to belong to a 12-year-old girl and he had communicated with children under 16 years online asking for nude photographs of them and he sent videos of himself masturbating. There were delays resulting from the forensic examination of his computer and the Police action was too drawn out and did not seem to deter sibling 1.

A Strategy Discussion was held in May 2018 about Sibling 1 at the Police's instigation. This was a positive development as there was little other active engagement with Sibling 1. The Adult Learning Disabilities team became involved, and an urgent referral was made to the Clinical Psychologist for an assessment to be made. Monitoring equipment was installed on his computer.

In February 2019, Sibling 1 breached the caution by contacting children online. There was also evidence that he had viewed websites in 2018 relating to brother and sister sexual intercourse. A referral was made to Children's Social Care.

5.8 Community Team for Adults with Learning Disability (CTALD) – Sibling 1

Sibling 1 was known to the Adult Learning Disability service from 2014. He was assessed as being an individual with high Functioning Autism. He was not regarded as having a learning disability although he was intellectually low functioning. His assessment mentioned his behaviour of anger and aggression as a concern but there was only a mention of him having a tendency to play with younger children. Sibling 1 was noted not to be a risk to others.

In March 2015, Sibling 1 started to attend day care at a farm two days a week. The Psychologist's opinion was that Sibling 1 was not a risk to others and that managing the challenges he posed required putting strategies in place to manage his behaviour. Another service for people with learning difficulties, Macintyre, refused to allow him to attend its café because he was thought to be a risk to others.

The CTALD service responded to the attack which Sibling 1 made on his stepmother in August 2015 by making a referral to the Behavioural Support Team for emotional recognition sessions. He only partially engaged with these. In January and March 2016, he was reassessed by Adult Social Care, but the risks posed by Sibling 1 were not fully considered in the light of more recent incidents. He complained about living in the family home and coping with his sister's self-harming. He posted on Facebook that he was going to drive his bike into a wall and kill himself.

In October 2016 there were concerns about Sibling 1 using the internet to contact young girls. In May 2017, he started to follow his girlfriend home from the Farm. In September 2017, he was arrested for assaulting a police officer. In November he was arrested for talking to underage girls inappropriately.

During 2018, Sibling 1's inappropriate behaviour increased and in May 2018, there was a police investigation relating to sexual offences. The Learning Disability Psychologist attached to the service carried out a risk assessment in June 2018 which found that the risk of reoffending remained high because of Sibling 1's lack of ability to learn from experience.

The CTALD service sought to enable Sibling 1 to develop his independence skills and to moderate his inappropriate behaviour. He received a range of support, but this involvement was not linked up with what was known to other agencies and was therefore not influenced or informed by that. The CTALD involvement did not fully recognise that Sibling 1's preference to spend time with younger children was a safeguarding risk to them. The 2018 Psychologist risk assessment was not updated, and it did not address his anger and aggression. The CTALD intervention was focused on Sibling 1. Sibling 1's whole family context which included younger children was not fully considered. There was a lack of joint working with children's services to look at their needs.

5.9 Adult Mental Health Services – Sibling 1

Sibling 1 referred himself in March 2017 to the Psychology Service reporting that he was stressed by friction with his girlfriend's foster mother. It is not clear that the age of the foster child was asked. Sibling 1 said he intended to end his life. During several other contacts in 2017, Sibling 1 continued to speak about his stress. In sharing information about his family Sibling 1 did not mention Child G.

In May 2018, Sibling 1 had streamed on Facebook a threat that he intended to end his life. He was seen by the Mental Health Hospital Liaison Team. He agreed to attend Talking Therapies and was then discharged. In November 2018, he was seen again at A&E where he was expressing suicidal thoughts. This he related to being arrested 25 times in relation to offences, not just sexual offences. A team meeting was held to discuss his offending, but information was not sought from MASH or advice from the services Safeguarding Children Team. Appointments were offered to Sibling 1 but he did not consistently engage. The potential risk that Sibling 1 posed to children was not fully explored or checked with other agencies.

In March 2019, Sibling 1 was seen in A&E saying he was depressed, and he expressed suicidal thoughts due to his pending court case. No information was shared with other agencies. It was not until March 2019, that a Psychologist from the mental health service contacted the Psychologist from the adult learning disability team. They were seeking advice on how to meet Sibling 1's needs and were provided with a clear account of the extent of Sibling 1's offending and the risks he posed. Both Psychologists are actually employed by the same Trust – however, there are clearly gaps in liaison arrangements which was not helped by the fact that they have a different client recording system so could not access each other's recordings.

5.10 CAMHS and Child G

Child G was referred by school to CAMHS in April 2019, but the referral was not accepted because no urgent mental health need was identified.

Following her disclosure of abuse in August 2019, Child G was seen within a few days by CAMHS because she was expressing that she wanted to kill herself.

6 Child G's Voice and Lived Experience

6.1 Child G has been seen once by the reviewer. She was very clear that she wanted the lessons from her experience to be learnt by agencies. She did not want another child to suffer the same abuse. The Reviewer was able to meet Child G on a virtual video-call. She was informed about this review and she was told that her views and experience were key elements for learning locally. At the time she was still living in the family home where the abuse occurred.

Child G was happy to speak to the reviewer with the hope that this would help another child's experience. Child G said that she had been diagnosed with complex Post-Traumatic Stress Disorder (PTSD) and has

been referred to the Adult Services. Child G stressed that she was happy to share her views with the review so that organisations can stop this happening to someone else a lot earlier. She said she had been going through all this alone since the age of 10 years with no support. In particular, she highlighted the lack of awareness in schools about sexual assault and about rape. Child G shared that, in her experience, nothing was being taught about this till Year 7, nor was there information about how you could speak to a police officer.

Child G stated that she had been disappointed that professionals had not identified her distress at an earlier point. She had become uncharacteristically difficult at school, but no one seemed to question why this was the case. She said that at the time no one knew what was going on at home or why her behaviour had changed in year 6. No one really picked up on it till Years 9 and 10. Child G said she used to get annoyed at people in school and would be told to leave the class, but no one really asked why Child G behaved the way she did.

Unfortunately, it was only possible to see Child G once because there was a deterioration in her mental health, and she was not available to see the reviewer again before the writing of this report.

6.2 Child G's family experience and upbringing was troubled, and she and her siblings appeared to have had several adverse childhood experiences. Her birth parents had an acrimonious relationship, and it seems that there was neglect of the children's basic needs. Her birth mother left with the children. When her birth mother had sole care of Child G and her siblings the children experienced abusive and neglectful care. Child G and her siblings were in care for a period after their mother had physically assaulted her brother, Sibling 1. Her mother was prosecuted for the assault on Sibling 1 and found guilty. Child G's father and stepmother contacted the Local Authority and agreed to care for the children. Both father and stepmother appear to be very needy and vulnerable with additional learning, medical and mental health needs. Whist in their care, Child G, siblings and step-sibling all showed symptoms of distress including self-harming and Sibling 1 and Sibling 3 were involved in inappropriate sexualised behaviour. There were several violent episodes in the household resulting in the police becoming involved. Child G had some contact with her birth mother, which disturbed her, but when her mother disengaged from this, Child G was again distressed by this.

6.3 Child G seems to have experienced considerable stress at home which she shared at times with school and other agencies. She shared problems with sleeping, worrying about other family members and from 2017 began to question her gender identity. At other times, Child G would state that she was happy at home and that all was well. Sometimes practitioners perceived Child G to be independent and mature. Agencies were responsive to her needs and acted in accordance with the young person's expressed wishes, even when it was not necessarily in the young person's best interests or required more checking out. Professionals needed to be more curious and to take a longer-term perspective in working with the family rather than using short term interventions.

6.4 Child G was displaying some concerning behaviour at school – punching walls, taking herself out of classes and having problems with friendship groups. On one occasion, she soiled herself at school. She said that she was "strapping" her breasts and taking hormones to check her own female development. It was understood that these behaviours were significant and that she needed support but the need to identify fully what might be causing it did not happen.

6.5 Child G had some additional needs in relation to cognition and learning and she received SEN support at school. She was described at school as "polite, well-mannered and eager to learn" and referred to as "a model student" in 2018. Child G's increasing tendency to avoid lessons later on was sometimes seen as

being related to her frustrations about not understanding her work and her additional learning needs. Her family problems and her gender identity questioning were perhaps too readily accepted as plausible explanations for her worrying behaviour at school. Child G has told the reviewer that she felt disappointed that the school and others did not ask more questions about why her behaviour overall changed so much.

6.6 Child G's childhood experience was very troubled. A polite child who wanted to please never really had her own needs met. The needs of others overshadowed hers and caused her worry, confusion and distress.

Views of Family including Sibling 1

6.7 Child G's brother Sibling 1 was interviewed as part of this review. The aim was to try and identify whether he had any information to share about why he abused his sister and whether he had any view about how this abuse continued for so long. We explained that we wanted to understand how we can prevent these things from happening again.

6.8 When Sibling 1 was seen, at times it appeared that he did not accept responsibility for his actions. He said he felt others should have stopped him from abusing Child G. He suggested that he had not realised that what he was doing was wrong. However, at other points in the conversation he acknowledged that he knew he should not have abused her. it is clear from Child G's disclosure that he coerced Child G and that he sought to conceal what he was doing. This certainly suggests that he was aware that he was doing wrong.

6.9 The reviewer would have liked to speak to other members of the family. However, Child G did not want this to happen. Therefore, it was decided that we would respect her wishes and they were not seen.

6.10 Since this review was finalised, Child G has spoken in October 2021 to the review and shared some additional views. These are set out in Appendix C.

7 Findings of the Review

These findings relate to the key areas of focus set out for this review.

7.1 **The degree to which professional curiosity and authoritative enquiry were exercised when responding to Child G's concerning behaviours.**
Child G's school had a positive relationship with Child G and she did share her worries. Her presentation was not always concerning and often she would say that everything was fine at home and that she was happy. When she shared her worries, the school referred her for support including to the MASH and Children's Social Care and kept in touch with other agencies. However, support was provided without anyone really asking why the problems recurred.

There was insufficient questioning by all agencies particularly Children's Social Care about the changes in Child G's behaviours and about the risk of whether Sibling 1's sexualised offending was having an impact on other family members including Child G. It appears that the Police were not aware of changes in her behaviour, and she was not always spoken to when Police were called to the family home.

It is likely to have been difficult to maintain consistent questioning of why Child G's behaviour changed because she was not consistent in her story about her life at home. At times, she would say how difficult it was but very shortly afterwards she would say that she had a positive relationship with her father and stepmother.

There was a lack of diligent enquiry and investigation even when opportunities arose to ask more questions and to exercise a greater degree of professional curiosity in relation to changes in Child G's behaviour. A great deal of help was provided to Child G but only as response to Child G's immediate presentation without further questioning about the cause of her behaviour – it was thought that enough was known and that there were no more deeper-seated reasons for her worries and behaviour.

7.2 **The degree to which professional curiosity and authoritative enquiry were exercised when considering and responding to Child G's gender identity.**

Child G's wish to change her gender identity was supported but the reasons for this change were not really questioned. This is ethically difficult because professionals had to consider whether this was her gender identity or whether additional factors were influencing her questioning of her sexuality. Professionals want to be open to accepting a child's view of themselves so to consider possible explanations for this wish to change is challenging without seeming to be biased or prejudiced about difference in sexuality or gender.

Since professionals were not considering at all that Child G may be being sexually abused by Sibling 1, making the possible link to her questioning of her gender and sexuality was just seen as being about her choices as a young person growing up. It may well be that is all that it was. Most of those who were involved with Child G had little knowledge, experience, or expertise in working with children who are being child sexually abused, therefore it was difficult for them to see beneath Child G's presenting behaviour and statements.

7.3 **The extent to which holistic assessments of the family were undertaken particularly taking account of working with a family with additional learning needs.**

There is no evidence that any agency involved with the family, Sibling 1 and Child G undertook a sufficiently holistic in-depth assessment of the family dynamics and circumstances. Some of the agencies involved appreciated the complexity of Child G's home life and the stress factors within the family for her but did not consider every possibility about what was happening. Father's and stepmother's capacity to keep the children safe was not fully assessed and their assurances that they would do this were accepted. For example, following the allegation in 2014 that Sibling 1 was having sex with Child G, the parents then and on many other occasions stated that they would supervise Sibling 1's contact with the other family members. However, it appears that this would have been difficult at night as they slept downstairs in a separate part of the house, but this was not questioned.

In 2014, there was an allegation of child sexual abuse by Sibling 1 in relation to Child G. This was investigated but the intervention was short-lived and ineffective because of on an overfocus on the need to obtain a disclosure from Child G. There was also an untested reliance on father and stepmother to keep the children safe. In reality, there was further scope for enquiry and there was forensic evidence which if tested may have proven that child sexual abuse, including full sexual intercourse, was taking place between Sibling 1 and Child G but this was not considered, and the Police were not involved in a joint investigation of what was an alleged crime as required by the local procedure.

In 2017, Children's Social Care carried out an assessment, based on a single visit to the home, in response to information from the Police about Sibling 1 grooming a child on social media. Father's reassurance that he did not feel Sibling 1 posed a risk to his siblings was accepted. Child G was seen and was positive about her relationship with father and stepmother. The outcome of the assessment was for the Children and Families Practice to work with Child G and her younger brother on protective behaviours. It was also noted that the parents should supervise any contact between Sibling 1 and his siblings.

Otherwise, the focus was in the main on the individual needs of family members. The Police did consider wider issues than individual family members. Child G rarely came to Police attention in her own right but there were occasions when she should have been approached and given the opportunity to share any concerns.

Above all, agencies did not work together consistently or have a shared view and overview of what was happening to Child G. Individual agencies were for the most part left to manage the issues in their own silos. There was no lead professional coordinating and taking an overview. Even when Children's Social Care and the Children & Families Practice were involved, they had very limited contact with other agencies. This was a very complex family situation, but its serious dysfunction was not accepted, and the responses were not family-centred even though the abuse, coercion and traumatic lifestyle in the family were detrimental to the whole family and enabled Sibling 1 to have scope to abuse Child G.

7.4 **Quality of risk assessments carried out in relation to Sibling 1 that took account of both his mental health, learning needs and the risk he potentially posed to children and vulnerable adults he had access to.**

Sibling 1 had shown escalating offending behaviours and, despite advice and warnings from the Police about this on many occasions, his behaviour continued. It appeared that his parents were unable to prevent him from committing offences though they gave undertakings that they could do so. However, the potential risk Sibling 1 posed to Child G and potentially other young girls was not always or fully identified. Sibling 1 was seen as being vulnerable and he added to this perception when he stated on many occasions that he was feeling suicidal. This vulnerability tended to be automatically attached to him as soon as it was identified that he had a diagnosis of autism. However, this was not considered appropriately and in the light of his capacity to make decisions and to choose to commit sexual offences, including offences against children. The impact of his assumed vulnerability was a lack of challenge to his actions and, as a result, there was a tendency for the focus to move from the victims of his offending to the perpetrator.

There were several social care assessments of Sibling 1 completed by the Community Team for Adults with a Learning Disability (CTALD) from its first involvement with him in 2014. Consistently these assessments said that Sibling 1 was not a risk to others. The 2014 assessment did draw attention to Sibling 1's tendency to play with younger children; it was said that this happened because he found it difficult to relate to people of his own age. No risk assessment was put in place in relation to this behaviour and other explanations were not considered. Sibling 1 was not seen as posing a risk to others, but the view was that there was a need to manage his behaviours – his anger and aggression. The Adult Learning Disability team knew about Sibling 1's serious assault of his stepmother in 2015. Sibling 1 was attending the Farm and they were advised to update their risk assessments. There was no contact with Children's Social Care to consider what risk Sibling 1 posed to his younger siblings. In reassessments in 2016, information from earlier assessments about Sibling 1 playing with young girls was cut and pasted over into the next assessment without any further reflection about whether this was a safeguarding concern and required further action.

In June 2018, a Clinical Psychologist, based in the CTALD service – carried out a home visit and an assessment regarding the risks related to Sibling 1's inappropriate relationships with female children. The focus was on assessment of his functioning and behaviour, particularly inappropriate sexual behaviour towards prepubescent children. Advice was given to Police, Social Care and Health professionals that Sibling 1's level of risk of reoffending was high due to his supporting beliefs and opinions with which he sought to justify what he was doing. Sibling 1 denied that the risk was high and lacked insight and minimised his previous offending behaviour. His father gave reassurances that he could keep household members including Child G safe. Father appeared to be highly protective of Sibling 1.

There was no risk assessment within the CTALD service in relation to Sibling 1's preference for the company of young girls or in relation to his anger and aggression. The intervention was focussed on Sibling 1 and on supporting him and addressing his needs. The team knew about the family composition and that there were younger children at home; it knew about his sister's self-harming and the physical aggression by Sibling 1 towards his stepmother. However, the connection was not made that Sibling 1 could be posing a risk within the household. There was no contact made with Children's Social Care nor a plan to prevent the risk that Sibling 1 would reoffend.

Other agencies, including Police and Children's Social Care, continued to see the parents as struggling to provide a safe and protective environment for the children. They were aware of the potential risks especially after the 2014 allegation but as Child G had not disclosed anything this was not followed through further. Even the Police, who knew the full extent of Sibling 1's inappropriate behaviour and offending did not identify the welfare and safeguarding of Child G, and potentially her other sister, as a major potential safeguarding issue. There was no effective risk assessment in place over a sustained period.

7.5 **Whether the parents were risk-assessed and supported to both care for Sibling 1 and keep Child G safe.**

As stated above, it is not clear that father's and stepmother's capacity to keep the children safe and to care effectively for Sibling 1 was fully assessed over anything but a short period. The complexity of managing Sibling 1's behaviours and keeping the other children safe from harm was underestimated. Their reassurance that they would keep boundaries around Sibling 1 and keep the other children safe were accepted and not challenged further. Some of the adult services involved with Sibling 1 had not even visited the family home and were not aware that there were other vulnerable young people, including Child G in the household.

This issue was considered in the Children's Social Care assessments completed in 2014 and 2017 and father's and stepmother's capacity to keep Child G and other members of the household safe was regarded as a concern. Child G was positive about her parents when spoken to. When the Children and Families Practice Team was involved from December 2017 to March 2018, father and stepmother were seen, and as issues about how they related to each other arose, it was suggested that they should attend a healthy relationships programme. They declined the option to be referred to this service. Child G was seen and talked to the worker, but she did not disclose abuse.

7.6 **How effectively agencies worked together and shared information about Sibling 1's risk and Child G's safety**

There is evidence of effective joint working between the school, young carers service and the School Nurse over the review period. There was regular discussion and sharing of events between them. However, when more worrying concerns about Child G arose, there was a lack of a more coordinated approach with a lead professional bringing information together with a clear joint plan in place. The school staff felt that they were being required to monitor and keep track of Child G's case without the support and expertise they needed to do this effectively.

Children's Social Care was involved briefly in 2014 and again in 2017. The interventions were short-term, and Child G did not disclose any abuse by Sibling 1. The family cooperated and Child G seemed to be happy in the care of her parents.

The 2014 incident when blood was found on Sibling 1's sheets as well as his sister's underwear was a missed opportunity to carry out a full joint investigation by Police and Children's Social Care, especially since there was potentially forensic evidence which should have been analysed.

Some of the Adult Services involved with Sibling 1 do not appear to have had much information about who was living in the household. Risks to the children from Sibling 1 were therefore not considered or addressed directly. Father was regarded as protective by those services. Adult Mental Health and Adult Learning Disability Services did not engage with each other for a long period. As a result, the approach to addressing Sibling 1's needs and the risks he posed were not fully effective. Neither of those services thought about the whole family context in which Sibling 1 was living or considering the needs and potential risks to children in that household from Sibling 1's sexually inappropriate behaviours.

The Police had a great deal of information about Sibling 1 and his offending behaviour. Much of this was shared in the MASH. However, the impact of this and the overall pattern of his offending and inappropriate sexual behaviour was not fully appreciated or shared either within the Police or with other agencies.

8 Conclusions and Summary

There was some good and effective practice evidenced in this case. A range of services supported Child G, but the abuse continued for a lengthy period. Sibling 1 was also provided with services to try and help him overcome his challenging and inappropriate behaviours though there was insufficient attention paid to his high risk of him committing sexual offences against young people.

There was a lack of a holistic and multi-agency approach to understanding the needs and experience of Child G and Sibling 1 within their whole family context.

Services tended to work in silos rather than adopting a mature, effective joint working approach. There is national and local learning from this case. These will require some developments of practice, policy and procedures by agencies and the MK Together Partnership.

There appears to have been a lack of expertise and experience of dealing with cases of child sexual abuse. A high reliance was placed on disclosure by the child victim, even when a family member continued to say she believed abuse had occurred, and other evidence was not pursued for long enough. Nationally, research evidence shows that child sexual abuse (CSA) is under-reported. It is described as "an alarmingly common form of abuse".

In this case the perpetrator, Sibling 1, appears to have used a variety of tactics to prevent disclosure, including using his autism as an excuse for his sexualised behaviours, presenting himself as vulnerable and likely to self-harm as well as threats to his victim and family members whenever he was challenged.

Allnock and Miller, 2013, have shown that two-thirds of all cases of CSA are committed by family members or persons close to the family, and therefore fear of family breakdown or a lack of a trusted person may inhibit disclosure. It is noted in the records how protective Child G was of all her family members, including Sibling 1 who she regarded as vulnerable. She also took on undue responsibility for managing the tensions at home with her father and stepmother telling the children about all their worries including health problems. Child G was described by one agency as very mature and as caring and organising her family. It would seem that, as a young teenager, she saw herself as responsible for holding things together at home.

Locally, there is a need to increase the proficiency and skill in every service at identifying the signs and behaviours which may indicate that child sexual abuse is occurring.

It is known from research that:

- Sexual abuse involving child siblings is thought to be the most common form of intra-familial child sexual abuse, perhaps up to three times as common as sexual abuse of a child by a parent
- The most common reported pattern of sibling sexual abuse involves an older brother abusing a younger sister, and most of what we know relates to this pairing.
- Sibling sexual abuse is verbally disclosed less often than sexual abuse by an adult, and it is vital that professionals have the knowledge, skills, and confidence to respond to disclosures adequately and appropriately when they do occur.
- Telling others may take all sorts of different forms and does not always involve a direct verbal account of the abuse. Retractions are also common.
- Sexual abuse involving child siblings is an issue that most child protection practitioners are likely to confront at some stage and it is therefore necessary to think the unthinkable.

[Yates P and Allardyce S. Sibling sexual abuse: A knowledge and practice overview – January 2021 Centre of Expertise on Child Sexual Abuse (CSA Centre)]

9. Recommendations for consideration

9.1 All agencies need to ensure that professional practice is child focused, focuses on safeguarding and considers the lived experience of all the children in a family. Adult and Children's Services need to ensure that children are safeguarded, and they must work together when necessary to keep children safe.

9.2 There is a need to raise awareness of the nature and prevalence of child sexual abuse and possible indicators of when it is present in family settings. The knowledge and skills of professionals need to be enhanced to ensure that the local area has the necessary expertise and experience which this issue requires.

9.3 The MK Together Partnership should ensure that the responses to allegations of child sexual abuse comply with the procedures. Police and Children's Social Care should review their joint investigative practice to ensure that joint investigations are carried out - particularly in cases of sexual abuse allegations – and are compliant with local policy and procedures and Working Together 2018.

9.4 All agencies need to develop a greater knowledge and understanding of the impact of autism and other learning difficulties on the capacity of individuals to function and to make appropriate choices. There should be autism champions in every service, who could pick up on individuals on the spectrum, and give specialist advice around consequences. When picked up at ground level, this should be immediately recognised and driven down correct pathway, so when you get a call from an agency that says they are working with an autistic person there is someone with specialist knowledge.

9.5 Consideration should be given to reviewing the current provision between Police and Adult Services for the risk assessment and management of sexual offending and harmful sexualised behaviours by individuals on the autistic spectrum. There appears to be a gap in this area which is inhibiting joint working and the sharing of information for public protection.

10. Next steps - Progress Report and Learning

The recommendations set out in the review will be considered by the MK Together Partnership. The recommendations by the author and agency report authors are made with the expectation that when the Partnership develops its Action Plan the actions will be more specific.

All the agencies have reflected on the learning to be gleaned from this case and have suggested and, in some cases, already implemented improvements; some progress has already been made in developing improved information sharing within and between health services.

As per the Terms of Reference, a separate multi-agency risk assessment review took place. This review looked at current risk assessment tools, how they are used and how information is shared to enable agencies to fully understand risks within families. A copy of the report was made available to the reviewer. It was recommended that there should be:

1. Recommendation 1: Development of standardised assessment of competence compliance in assessing sexual risk across MK Together partner agencies.
2. Recommendation 2: Adoption of a risk assessment tool within adult services (including LDT) based on the signs of safety model.
3. Recommendation 3: Development of awareness training offer to all adult service workers in relation to the assessment of risk of adults known, or suspected of, posing a risk (including sexual risk) to children. This should include assessment of the ability of care givers to keep children or vulnerable adults safe.

This Reviewer would endorse all those actions. However, as discussed above, there is more emphasis required within adult services on the vulnerability of children and of safeguarding concerns being a primary focus at all times.

In addition, all staff in the City need to raise their awareness of sexual exploitation generally and of child sexual abuse in particular.

Appendix A: Scope and Full Terms of Reference

MILTON KEYNES REVIEW BOARD

CHILD SAFEGUARDING PRACTICE REVIEW

Terms of Reference and Scope

Subject: CHILD G

1. BACKGROUND INFORMATION

Child G, aged 16 years old, was the victim of sexual abuse, including rape by her brother Sibling 1, now aged 25, over a five-year period in the family home. Sibling 1 has a diagnosis of autism and learning difficulties and has a history of inappropriate sexual contact with children. At the time of the disclosure Sibling 1 was under investigation for attempting to groom a child online and was known to have accessed websites to watch brother-sister pornography. Child G does not have contact with her biological mother due to previous neglect and was in the care of her father and stepmother. Both father and stepmother also have learning needs and were the main carers for Sibling 1. Whilst known to be a risk of sexual offences, Sibling 1 had access to Child G and also worked in a farm frequented by children and attended a day centre for vulnerable adults. Sibling 1 has been convicted and is currently serving a prison sentence.

2. SCOPE OF THE REVIEW

The scope of the review is 1 October 2014 - when Sibling 1 first came to the attention of the police for possible inappropriate contact with children, until 3 August 2019 - when Child G made the disclosure. Agencies are invited to provide any other relevant information outside of this time period, including post disclosure.

3. TERMS OF REFERENCE

The National Panel has determined that the case meets the criteria for a Local Child Safeguarding Practice review on the basis that:

- A child has suffered significant harm
- Abuse and/or neglect were a contributory factor

Working Together to Safeguard Children 2018, expects the following of reviews:

- *Improvements needed to safeguard the welfare of children*
- *Recurrent themes in safeguarding practice*
- *Concerns regarding two or more agencies working together to safeguard children*
- *Concerns about a single agency's ability to safeguard children*

The Child Safeguarding Practice Review will follow the Welsh Model to build upon the learnings already identified in the Rapid Review. This will consist of

- Key events chronologies and IMRs from agencies
- Interviews with key personnel to explore good practice, missed opportunities and learning.

- A separate Child Safeguarding Practice Review Panel consisting of senior managers from relevant agencies
- An Independent Author who will Chair the Panel and write the overview report

The review will focus on:

- Risk assessments carried out on Sibling 1 that took account of both his mental health, learning needs and the risk he potentially posed to children and vulnerable adults he had access to.
- How the parents were risk-assessed and supported to both care for Sibling 1 and keep Child G safe.
- How agencies shared information about Sibling 1's risk and Child G's safety.
- Professional curiosity when responding to Child G's concerning behaviours.
- Professional curiosity when responding to Child G's gender identity.
- Holistic assessments of the family and working with families with learning needs.

- The review will include:
  - A lessons-learned report by the independent reviewer, focusing on learning rather than the events.
  - A conclusion as to whether as a result of learning from this case, any changes are required to practice, policy or procedures by individual or collective agencies.
  - Recommendations demonstrating the Case Issue, System Issue and Recommendations.

The review panel will require expertise from professionals on working with adults with autism, parents with learning needs and transgender children.

A separate multi-agency risk assessment review has taken place. This review looked at current risk assessment tools, how they are used and how information is shared to enable agencies to fully understand risks within families. Learning from the risk assessment review will inform any immediate changes to practice and a copy of the report will be made available to the reviewer.

Publication

The report will be presented to the MK Together Management Board and published on the MK Together and NSPCC websites.

3.1. Agencies Contributing to the Review

- Children's Services (MASH, Children's Family Practice, Children's Social Care)
- Adult Services, Learning Disability Team
- Thames Valley Police
- CNWL (School Nursing, CAMHS, Adult Mental Health Service)
- Child G's school during the period
- Brook (young person's sexual health service, if identified either accessed the service)
- Q:alliance (young person's LGBTQ Service)
- Sibling 1's Day Centre
- Family GP

4. FAMILY INVOLVEMENT AND INDEPENDENT AUTHOR REPORT

The review will seek the involvement of Child G, her father and stepmother. The criminal proceedings have concluded, and Sibling 1 is in HMP Rye Hill. His involvement will be sought for this review.

Appendix B: List of References

Allnock D and Miller P (2013) *No one noticed: a Study of disclosures of childhood abuse*. NSPCC London

Brandon M, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black - *Analysing child deaths and serious injury through abuse and neglect: what can we learn?* A biennial analysis of serious case reviews 2003-2005.

Brandon M, Sue Bailey and Pippa Belderson - *Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009*; DFE 2010

Brandon M, Peter Sidebotham, Sue Bailey, Pippa Belderson, Carol Hawley, Catherine Ellis & Matthew Megson - University of East Anglia & University of Warwick – July 12: *New learning from serious case reviews: a two-year report for 2009-2011.*

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Editorial – *Child Sexual Abuse: Common, under-reported and concomitant with other maltreatment*

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Department for Education (2021) *Tackling Child Sexual Abuse Strategy*

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S47 Joint Investigation
https://mkscb.procedures.org.uk/ykyxsl/assessing-need-and-providing-help/multi-agency-safeguarding-hub-mash/section-47-enquiries#

NSPCC Learning from Case Reviews Briefing February 2021 – *Teenagers: learning from case reviews briefing*

Ofsted - *The voice of the child: learning lessons from serious case reviews.* A thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010.

Ofsted – *The multi-agency response to child sexual abuse in the family environment* – February 2020

Parke S and Karsna K
Measuring the scale and changing nature of child sexual abuse - July 2019
Analysis of 2017/18 official and agency data - Centre of Expertise on Child Sexual Abuse (CSA Centre)

Research in Practice - *2019 Triennial Analysis of Serious Case Reviews: Local safeguarding partnerships*

Yates P and Allardyce S - *Sibling sexual abuse: A knowledge and practice overview* – January 2021
Centre of Expertise on Child Sexual Abuse (CSA Centre)

Appendix C: Additional direct comment from Child G, provided October 2021

Child G has asked that the report is amended to include their views. The Reviewer has also written to Child G to acknowledge the comments and to respond to them.

1. Child G said schools should have social workers working there.
   The Reviewer responded: I think this is a good idea. Above all social workers need to work closely with schools and listen to them.

2. Child G said there should be a male and female welfare officer in schools.
   The Reviewer responded: I think this is a good idea. Schools should be told what he has said.

3. Child G pointed out that none of the professionals thye met made enquiries to understand why Child G was destructive and misbehaving in school.
   The Reviewer responded: I agree and said this in the review. Professionals need to be curious and ask why.

4. Child G pointed out that in the October 2014 incident, Police did not attend the house. Police did not speak to Child G or their parents.
   The Reviewer responded: You are right. The Police should have been there as I say in the review.

5. Child G said they wanted to speak to professionals about their experience.
   The Reviewer responded: I have said in the review that professionals need to be made aware of abuse like you had. They need training and your experience would be good then.

It is extremely positive that Child G has been able to contribute to the Review. It was unfortunate, as they have shared, that Child G was previously too unwell to do so.