Local Child Safeguarding Practice Review (LCSPR)

Isaac, Sibling 1 and Sibling 2

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1. Introduction and context for the Review

1.1 This independently led Local Child Safeguarding Practice Review[1] (LCSPR – to be described simply as 'review' from this point) is about Isaac, who reported at age 10, that his siblings had behaved in a sexually inappropriate way towards him. Some months later Issac reported that he had been sexually abuse by sibling 1, and then 10 months after that, Isaac reported being sexually abused by sibling 2. There were concerns about how well these disclosures of sexual abuse by Issac were responded to by the multi-agency group and a serious incident notification[2] was submitted to the Wigan Safeguarding Childrens Partnership.

Process of the Review

1.2 Rapid Review reports were sought from all involved agencies, and a Rapid Review meeting held. The single agency reports were subject to detailed analysis and agencies were asked to provide clarification about key issues. This formed an excellent starting point for the independently led Local Child Safeguarding Practice Review (LCSPR) commissioned by Wigan Safeguarding Childrens Partnership. An Independent Reviewer, Jane Wiffin[3], was commissioned. Single agency action plans were agreed, and actions monitored by the panel as part of the review process.

1.3 A panel of senior managers from all agencies involved with Isaac and his family were brought together to oversee the LCSPR process and to be a critical friend to the independent reviewer who was responsible for the early analysis of available data and production of this report. The chair of the panel was the Service Lead for Children's Safeguarding at Wigan Council.

1.4 Interviews were conducted with those professionals who worked with Issac, his siblings, and his family. They have provided a very helpful analysis and context for understanding the gaps and enablers to responding to child sexual abuse generally, and sibling sexual abuse specifically. Information was sought about key meetings and reports and plans, such as within the child protection and child in need process, which were part of the data analysis process of the review. The Learning and Improvement subgroup were regularly updated about the emerging learning from the review. Some of the work emanating from this is outlined in section 5 of this report regarding recommendations.

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[1] A **Local Child Safeguarding Practice Review (LCSPR)** is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death, and/or there is cause for concern as to the way in which agencies have worked together to safeguard the child. The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children. The statutory guidance for Serious Child Safeguarding Reviews is contained in Working Together to Safeguard Children 2023 A guide to multi-agency working to help, protect and promote the welfare of children. Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)

[2] See Report a serious child safeguarding incident - GOV.UK (www.gov.uk)

[3] Jane Wiffin is an Independent Reviewer with a professional background in social work.

1.5 A workshop was held with professionals from across the multi-agency safeguarding partnership who were not involved in this case. This was to establish whether the emerging themes from a review of Isaac's circumstances resonated with practice more widely. These professionals were able to tell us about some of the barriers and enablers to practice. These are included in the analysis section of this report.

1.6 The whole process was overseen efficiently by the Business Manager and Business Support Officer from the Wigan Safeguarding Childrens Partnership.

1.7 All these professionals have been a helpful part of the process, and the author would like to thank them for their time and thoughtfulness.

Family Involvement

1.8 A meeting was arranged with Isaac's father and his partner. Father spoke to Isaac about whether he would like to give his views, and he said that he did not feel able to at this time but wanted his father to speak for him. Contact has not been possible with sibling 1 or sibling 2, both of whom are living in another Local Authority with their mother. Mother initially said she would like to speak to the reviewer but has subsequently said she did not feel able to do so.

1.9 Father spoke about the impact of sibling sexual abuse on Isaac, on the siblings and the whole family. His views are very much in line with recent research which highlights the devastating impact of sibling sexual abuse; the concern about the child who has been harmed, the worry about those who have harmed, and the overwhelming sense that as a parent you want to protect and look after all of them. He felt torn by loyalties to all his children. He struggled with a lack of certainty about when they might all be able to be together as a family in a safe and appropriate way. He felt disappointed about the lack of services for Isaac, the way in which Isaac's distress was often criminalised through police involvement and a genuine worry that Isaac had mental health needs that were not being met. He accepted that these were likely caused by the trauma of the abuse.

1.10 He expressed a commitment to working with professionals, though did not always feel that there was swift or open communication. He accepted at times he was also overwhelmed by the enormity of the circumstances, and this had impacted on his work, wellbeing, and health. He and his partner continue to be confused about the issue of the ongoing criminal processes. These are all themes picked up in the analysis section.

1.11 Wigan Safeguarding Childrens Partnership would like to thank Father and his partner for the time they gave to provide feedback.

2. The Family

The family are all white/British.

2.1 Isaac, sibling 1, and sibling 2 moved to Wigan in 2016 to live with their father. Prior to this time, they were living with their mother and experienced some instability in their living arrangements due to homelessness and their mother's significantly acute health needs. There is some evidence this caused anxiety and uncertainty for the three boys. There is little more known about the period before they moved or about their mother or their parent's background.

2.2 The three boys were in a regular routine of staying with their mother and had regular contact with other members of their extended family. sibling 2 and sibling 1 struggled when they moved to secondary school in Wigan, with periods of poor mental health, self-harm, and fights with other children; there was also evidence of cannabis use which was of concern. Support and counselling were put in place by school, both were seen by CAMHS[4], but they reported that this was unhelpful.

2.3 Isaac was described as a happy go lucky child, who was well behaved and interested in learning when he moved to the local primary school in Wigan. In the period before the review started there was an unsurprising deterioration in his behaviour and mood. The school put in support, counselling and kept a close eye on him. There was always a member of the school staff available to talk to him and he reported to his father that he valued this and made good use of it. This was good practice by the school.

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3. Chronology of review period: November 2021 to February 2023.

This chronology is not a comprehensive list of all events and professional involvement. It is a summary of the key points during the period under review.			
2021			
Date	Key point	Response	Commentary: what would have been best practice at this point. be helpful.
November	Isaac (aged 8) told his headteacher that sibling 1 had behaved in a sexually inappropriate way towards him.	School made a referral to Wigan Children's Multi-Agency Safeguarding Hub (MASH[5]). Agreed a Child and Family Assessment[6]. Isaac's school put in place support and counselling.	It would have been expected that a strategy discussion would have taken place. The lack of the strategy discussion[7] meant that the police were unaware of this concern and so were sibling 1's school who were therefore no aware of the need for a safety plan.
2022			
February	The child and family assessment was concluded in February 2022.	Conclusion was a referral to early help who would provide: • Behaviour management support for father. • Direct work regarding online safety. • Review of the safety plan.	The early help plan did not happen because Isaac made further disclosures and became subject to a child protection plan. The agreed actions were not included in the child protection plan, leaving the needs of the whole family unmet.
16 February	The social worker made a referral to	It was highlighted that it would be important for the assessing practitioner to review the	

[5] MASH (Multi Agency Safeguarding Hub) is the forum for different agencies to work together in a common way. It is a single point of referral for all agencies and the public in relation to care and welfare of children (unborn – 18 years).

[6] Child and family Assessments involve collecting and analysing information about children, young people, and their families with the aim of understanding their situation and determining recommendations for any further professional intervention.

[7] A strategy discussion is a meeting between professionals from different agencies to decide whether the threshold has been met for a single or joint agency child protection investigation, and to plan that investigation. They happen when it is believed a child has suffered, or is likely to suffer, serious harm. The discussion should involve a first line manager from Children's Services, a detective sergeant from the police, other agencies as appropriate, and the referrer, if they are a professional

	CAMHS[8], and this was reviewed.	referral information about sexual trauma to prepare for the assessment.	
1 March	Isaac told the school counsellor that he and sibling 2 were involved in delivering drugs and smoking cannabis.	A strategy discussion was convened.	There was no action to respond to the early signs of criminal exploitation. (see the analysis section that follow for discussion of this).
1 March	Isaac told his headteacher that he had been sexually abused by sibling 1.	Referral to Wigan MASH and strategy discussion agreed. Police were notified. Police officer visited the family home and took an early witness statement from Isaac who provided a clear witness statement.	Isaac was unclear why, after having produced a witness statement he needed to be interviewed again. Issues should have been made clear at the time.
3 March	Strategy discussion held.	A joint police/social work child protection enquiry was agreed, including a joint visit for Isaac to be asked if he wanted a police investigation to go ahead. Family safety plan agreed.	There does not appear to have been any discussion about whether placing the responsibility for deciding about the police investigation on Isaac was appropriate.
4 March	Isaac told the school counsellor that he had also been sexually abused by his older sibling 2.	He was visited by a social worker and withdrew the disclosure.	A follow up strategy meeting should have been convened. Instead, Isaac's retraction was taken at face value without further exploration. This is discussed in the analysis section of the report.
4 March	The social worker phoned CAMHS to share information about the recent disclosure from	It was agreed that this new disclosure would not be discussed because of ongoing investigatory processes.	The Crown Prosecution Service guidance[9] makes clear what can and cannot be discussed

[8] CAMHS stands for **Child and Adolescent Mental Health Services**.
CAMHS is the name for the NHS services that assess and treat young people with emotional, behavioural, or mental health difficulties. Guide to CAMHS | Mental Health Services | Young Minds
[9] Pre-Trial Therapy | The Crown Prosecution Service (cps.gov.uk)

	Isaac ahead of the planned appointment.		when there are ongoing criminal processes in place and the importance of the sexual abuse and the trauma to be acknowledged. This is covered in the analysis section.
7th March	Father took Isaac to CAHMS appointment. Isaac was very distressed during this visit.	Outcome: 1. Referral to GP for an assessment of Father's concerns about oppositional defiance disorder (ODD)[10] or attention deficit hyperactivity disorder (ADHD).[11] 2. Referral to MASH regarding a photo that indicated Isaac was subject to criminal exploitation. 3. Referral for counselling.	There was no follow up strategy discussion regarding the ongoing concerns regarding criminal exploitation as would have been expected.
7 March	Joint police/social worker visit planned.	Isaac had run away from home. Appointment rescheduled.	
	Child protection enquiry completed.	Conclusion that all the children were at risk of significant harm and an Initial Child Protection Conference[12] to be convened.	This was appropriate.
18 March	Home visit to see Isaac by social worker and police officer planned.	This did not take place due to Isaac being distressed and running away from school. This was rescheduled to April.	

[10] Oppositional defiant disorder (ODD) is listed in the DSM-5 under *Disruptive, impulse-control, and conduct disorders* and defined as "a pattern of angry/irritable mood, argumentative/defiant behaviour, or vindictiveness. More recent thinking links this to trauma and trauma related distress. Psychiatry.org - DSM

[11] Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE

[12] An Initial Child Protection Conference is the meeting where the discussion first takes place, and a decision is made as to whether the child or young person should be subject to a Child Protection Plan and to start to develop that plan. A Review Conference is the term used for subsequent conferences. At Review Conferences the Child Protection Plan is looked at and a discussion takes place as to whether the outcomes intended from the Plan have been reached and whether the child or young person is safe.

23 March	Initial Child Protection Conference (ICPC[13]).	Isaac was made subject to Child Protection Plans for sexual abuse, and sibling 1 and sibling 2 for emotional abuse. sibling 1 to be schooled from home. He went to live with his mother. Family put safety plan in place ensuring that all children had contact with both parents. The plan was for Isaac to be supported through a referral to specialist counselling provided by SARC[14] and the need for a CAMHS, referral to be revisited. This referral was not made. Direct work around criminal exploitation was planned and consideration of an AIMS2[15] assessment for Sibling 1.	It was good that Isaac and his siblings were made subject to CP plans. The agreed actions, however, did not include support to the whole family, or to the parents. Behaviour management support, to address the children's distress was in the early help plan but was missing here. This would have helped. There was no clarity about direct work for Isaac, sibling 1 or sibling 2 whilst waiting for specialist support, which was predicted to take time to organise. The actions of Isaac's school, their provision of counselling and support were not acknowledged in the CP plan.
April	Joint agency police/social work visit planned.	This was a single agency, social work visit. It is unclear why. The police decided after this not to pursue a criminal investigation on the basis that Isaac did not want it to happen.	The lack of police attendance at this visit meant neither Isaac nor his father understood police decision making. The police officer attendance could have addressed Isaacs concerns

[13]

[14] A Sexual Assault Referral Centre (SARC) can offer confidential medical and practical support to people who have recently been raped or sexually assaulted. SARCs are usually provided by the NHS.

[15] AIM3 is an assessment framework designed to help practitioners consider relevant targets for intervention, in addition to quantifying risk and levels of supervision. The AIM Project – The AIM Project

			about the criminal process. Ultimately Isaac and the family were surprised that there was no police investigation. They did not understand why.
May	Agreed that Isaac and sibling 1 would have different social workers.	This was in response to concerns that each child had different needs, and there was often a conflict of interest.	This was good practice though Isaac's Father said this caused some confusion, duplication of meetings and need to repeat concerns. He did understand why this decision had been made.
June	Review Child Protection Conference.	• Police investigation halted. Said to be due to Isaac not wanting this to progress. • Direct work with Isaac had not been completed. • Isaac remained on waiting list for SARC counselling. • CAMHS could offer no support. • School remained the main support mechanism for Isaac. The school counsellor was told that she should not talk about the sexual abuse. • AIMS2 assessment progressing.	It is of concern that there was some dismissiveness and negativity about Isaac's behaviour which was not recognised as distress but described as poor behaviour. There remained a belief that because of a police investigation that the sexual abuse could not be discussed with Isaac, (see analysis). School action still not included in CP plan.
June	Headteacher/Designated Safeguarding Lead	Headteacher/DSL contacted the education safeguarding lead and concerns about delays escalated to the chair of	Good practice to challenge delays to support, but little action was taken.

	(DSL[16]) at Isaac's school remained concerned about Isaac's wellbeing and that he had not been provided with any specialist support.	the child protection conference[17].	
July	Core group	Isaac's headteacher expressed concern about the slow progress of the child protection plan. After the conference the headteacher/DSL asked for concerns to be escalated in line with the partnership escalation process[18].	Effective use of the escalation process.
August	Isaac's Education and Health Care (EHC[19]) application discussed.	The EHC panel rejected the application, saying they did not have a sufficiently full picture of Isaacs needs.	Wigan's Children's Social Care had not provided any of the requested information, this meant that the panel were not aware of Isaac's needs. The school had to continue to fund specialist support out of their own budget. There remained a disconnect between school's level of ongoing support to Isaac and the CP plan.
August	Isaac was taken by father to see the Community	The plan was for there to be contact with	It would have been important for the Community

[16] The designated safeguarding lead is the person appointed to take lead responsibility for child protection issues in school. The person fulfilling this role must be a senior member of the school's leadership team.

[17] Independent Reviewing Officers (IROs) are professionals who are responsible for ensuring that the welfare of children who are in care is safeguarded and promoted. They chair **c**hild protection conferences and **l**ooked after child reviews **t**o ensure that the care plan for the child meets their current needs and that decisions following the review are put into action

[18] Resolving Professional Disagreements/Escalation Policy. Resolving Professional Disagreements/Escalation Policy

[19] An EHC plan is a legally binding document outlining a child's special educational, health, and social care needs. The document has to list all of the child's special educational needs, provision to meet each of the needs and that provision has to be specific, detailed, and quantified. What is an Education, Health, and Care Plan (EHCP) (educationadvocacy.co.uk)

	Paediatrician because father's concerns about Isaac's aggressive behaviour.	Isaac's school and a follow up meeting.	Paediatrician to be aware of the concerns about sexual abuse to have a full picture of Issac's needs.
	Isaac was discussed again at the EHC Panel.	Conclusion that EHC assessment not needed at this point. Proposed an Educational Psychology assessment.	Action to address who attends the EHCP Panel and what information is provided is addressed in the single agency plans.
October	The headteacher escalated her concerns about lack of progress of EHCP for Isaac to the Director of Children's services.	Led to consideration of alternate educational provision (PPU[20]).	Good use of escalation process.
November	The AIMS2 assessment of sibling 1 was completed	This highlighted that sibling 1 (who was living with mother) and required high levels of supervision.	It would have been expected that there would have been an assessment of mother's ability to provide supervision and to consider support to be provided. This did not happen.
November	Review child protection conference.	There remained no therapeutic support in place for Isaac and he was unsettled at school. Father had some stress related health conditions and mother was also worried about her physical and emotional health. It was noted that Isaac would not be able to have any contact with sibling 1 until the SARC counselling had been	It is of concern that the issue of likely child criminal exploitation had not been addressed. The stepdown to child in need suggested that the risks had been assessed and managed. This was not fully the case. (see recommendation section of the report).

[20] Alternative provision as 'education arranged by local authorities for pupils who, because of exclusion, illness, or other reasons, would not otherwise receive suitable education. The most common type of alternative provision is a pupil referral unit (PRU).

		completed. There was no discussion of how this would then be managed. Recommendation that Isaac and sibling 1 become subject to child in need plans. It was agreed that sibling 2 did not need to be included.	
November	Isaac moved to the PPU alternative education provision.	He immediately struggled to manage his distress and behaviour.	
December	The PPU became concerned about Isaac accessing extremist material about racism and Nazism. He also expressed concerning and harmful discriminatory views.	The PPU contacted the lead social worker and made a referral to the Prevent team[21]. This was discussed with the Channel[22] team but was said to not meet the threshold for further action. The PPU were reassured that they were right to be concerned.	These concerns should have been subject to assessment to understand their meaning in the context of Isaac's distress and needs in the context of likely exploitation.
2023			
12 January	Isaac told his father that he had been sexually abused by sibling 2.	Contact was made with the social work team. Isaac's social worker was away but a duty social worker visited the next day.	The family were left to develop their own safety plan, without advice and which was not written down so could not be reviewed. This should have been a collaborative task for the child in need process, including the family and multi-agency colleagues.
20 January	Strategy discussion	This strategy meeting only focussed on Isaac, not sibling 2 and put the onus on Isaac to decide	The strategy meeting's purpose was to decide what action is needed to

[21] Prevent. Working with other organisations, the police protect vulnerable people from being exploited by extremists through a Home Office programme called Prevent. The role of our Prevent Officers is to help people vulnerable to radicalisation move away from extremism.

[22] Channel and Prevent Multi-Agency Panel (PMAP) are part of the Prevent strategy. The process is a multi-agency approach to identify and support individuals at risk of being drawn into terrorism. Channel and Prevent Multi-Agency Panel (PMAP) guidance - GOV.UK (www.gov.uk)

		what action should be taken.	keep all children in safe. The focus was only on the child who had been harmed, Isaac, and he was left with the developmentally inappropriate task of deciding next steps. There was confusion here about what is 'listening to the voice of the child' and what was professional responsibility to keep other children safe.
20 January	A joint police/social work visit	Isaac confirmed the disclosures against sibling 2. He agreed to a medical examination and to have an ABE[23] interview. He then decided that he did not feel able to do this.	
23 January	Isaac's mental health deteriorated, with self-harm and distress characterised by anger and violence.	Father took him to A&E and an appointment with CAMHS was agreed.	
The police investigation continues. Isaac completed an ABE/VRI interview in February. Isaac's EHC application was resubmitted, and it was agreed that an EHC assessment would take place. The three siblings continue to live separately. A critical incident notification was completed to review the professional response to Isaac and his siblings.			

[23] The primary purpose of the ABE/video recorded interview is to gather evidence for use in the investigation and criminal proceedings and to be the evidence in chief of the witness. Achieving best evidence in criminal proceedings - GOV.UK (www.gov.uk)

3. Analysis and key Findings

3.1 The purpose of any child safeguarding practice review (LCSPR) is to identify any improvements that need to be made locally and nationally to safeguard and promote the welfare of children and to seek to prevent or reduce the risk of recurrence of similar incidents.[i]. This Review was commissioned to look at multi-agency practice in the context of sibling sexual abuse.

The current context.

3.2 The starting point is to reflect on national concerns about the confidence and ability of safeguarding professionals to identify, respond and provide appropriate interventions and support to children and their families impacted by child sexual abuse. Although there is uncertainty about the exact number of children who have been sexually abused, a recent analysis of data from a range of agencies[ii] reveals that more than one in ten children had been sexually abused by the age of 16; this is much higher for girls (15%) than for boys (5%). Despite the evidence that the incidence of reported child sexual abuse has risen the number of child protection plans for sexual abuse has decreased significantly over the last few years; there were just 2,600 children on child protection plans under the primary category of sexual abuse across the whole of England in 2019/20. This was despite there being 87,992 identifiable child sexual abuse offences recorded by the police in the same year, and 30,460 children assessed as being at risk. At the same time, there were fewer prosecutions and fewer convictions in 2019/20 than three years ago. Simply put currently only 1 in 8 children who have been sexually abused will come to the attention of services or receive the help they need[iii].

3.3 These figures cover children being abused by adults and other children. A recent research project focussed on sibling sexual abuse[iv] has reported that sibling sexual abuse is the most common form of child sexual abuse in the UK. Estimates vary considerably but suggest that a child is two to five times more likely to be abused by their sibling, under the age of 18, than by a parent or adult living in their home environment. Nearly a quarter (24%) of reported incidents of intrafamilial sexual offences and assaults, where the victim was under 18, to the police in England and Wales from 2017-2021 was sibling sexual abuse. Despite these figures, sibling sexual abuse is one of the least likely forms of sexual abuse to be identified and there appears to be a significant amount of confusion amongst professionals, with little training or guidance regarding how to assess and respond.

3.4 The reflections emerging from this LCSPR chime with many of the national concerns and gaps in what ‘good’ looks like in responding to sibling sexual abuse. These are:

- **Theme 1: Enabling children to talk about sexual abuse: supporting help seeking behaviour.**
- **Theme 2: The Immediate response to sibling sexual abuse and harmful sexual behaviours.**
- **Theme 3: The longer-term response to sibling sexual abuse.**
- **Theme 4: Understanding and responding to the impact of sexual abuse.**
- **Theme 5: Support for non-abusing parents and the whole family.**
- **Theme 6: Responding to the potential signs of child criminal exploitation.**
- **Theme 7: The role of routine child protection processes in meeting the needs of children.**

3.4 Underpinning all these themes are the need to understand family history, family trauma, and concerns about relationships, and dynamic co-existing vulnerabilities of parents such as, domestic abuse and mental health needs and an understanding of previous parenting histories and children's experience of neglect or other forms of abuse. This enabled causal factors to be considered, risk to be understood, safety plans to be put in place and needs met. The assessments completed in response to concerns about sibling sexual abuse and early concerns about criminal exploitation did not explore family history, previous parenting, or family relationships. There are glimpses that mother might have struggled when the boys were younger, and it seems likely that they had lived in chaotic and unsettling circumstances and experienced neglect. There were issues related to mother's health and an accident which caused all the children some anxiety. We know that mother and father separated, and the boys came to live with their father. He had different relationships, and the police described some disputes in the early years when they returned to Wigan. There is no information about either mother or father's childhood. This information was needed to understand what might be impacting on the distress we saw for sibling 1 and sibling 2 and what help they might need. The parents were left to manage some complex circumstances, without reflection on their own histories and circumstances, support networks and resilience or lack of it.

3.6 In essence this is Isaac, sibling 1, and sibling 2's journey through services.

Theme 1: Enabling children to talk about sexual abuse: supporting help seeking behaviour.

3.7 At the start of this review period in November 2021, Isaac was able to report to his headteacher that sibling 1 had behaved in a harmful sexual way towards him. The school collectively had noticed a deterioration in Isaac's behaviour, and they actively offered him time and opportunity to talk about what was worrying him. They saw him and noticed him. These are key enablers in children being able to talk about abuse. Isaac clearly saw his school as a safe place. The school were good at reassuring Isaac that he had done the right thing and action would be taken. The school took immediate

action. A referral was made to the MASH and the school put in place support and counselling for Isaac. There was a child and family assessment completed in February 2022. This led to a decision for there to be support from early help and closure to children's services. The police had never been involved and Isaac may have wondered what the impact was of his reporting that he had been abused, whether he felt he had been believed or his concerns and his help seeking behaviour taken seriously. It is not known because he was not explicitly asked.

3.8 Soon after this stepdown process[24], in March 2022, Isaac told his head teacher that he, in the recent past, had been raped by sibling 1. It is possible that he worried about the lack of response to his previous sharing of concerns about abuse. This led to a strategy meeting and the start of a police investigation. Isaac was visited at home and gave a full outline of non-recent sexual abuse by sibling 1. A further joint police/social work visit was attempted but did not take place because of Isaac being distressed and running away from home. It may be that he thought he had already provided a witness statement and that there was no further need for him to talk to the police. It is unclear in the first responder interview with Isaac whether it was made clear that Isaac would need to repeat his disclosures. This would mean a third time of reporting what had happened to him. More thought needs to be given to how traumatising this can be.

3.9 In the same period, Isaac told his school counsellor that sibling 2 had sexually abused him; something he would retract and then later tell his father. This was shared with the MASH. This led to no further discussion. It appears that he was not asked further about this by any agency. His retraction was accepted. In the context of help seeking behaviour, children rarely lie about abuse. Retractions need to be explored in the context of the enormous barriers faced by children talking about abuse. They need to be explored and children asked about why they have made the retraction. This did not happen for Isaac.

3.10 The police considered that they should take no further action because Isaac was said to not want to give a further statement in the context of an ABE/VRI interview and there was also a focus on a medical examination which he did not consent to. It is not clear how this no further action was communicated to Isaac or what he understood by it. There is concern nationally that children, and their families can see no further action by the police as evidence that the child has not been believed, and the abuse did not happen. It is critical that this misperception is responded to.

3.11 There was an Initial Child Protection Conference, with a referral for specialist support. This took over 11 months to action. It remains unclear how this delay was communicated to Isaac, and whether he understood this.

[24] Step-down is a term used in child protection services to describe the process of moving a child or family from requiring statutory services to universal services. It enables professionals from Children's Services and multi-agency early help services to support the child/family intervention and plan.

3.12 Overall it seems likely that what was communicated to Isaac was that he had not been heard or believed. This possibility was not considered or discussed in the many meetings and reports in the child protection planning process. Isaac spoke to his father about his confusion about what was happening. In fact, it is of concern that the child protection records highlight that somehow the lack of criminal action was Isaac's fault for not engaging with a medical examination or the ABE/VRI process. *'Isaac did not wish to have a CP medical, nor to have Sibling 1 prosecuted. The Police investigation did not therefore progress'.*

Why does this matter?

3.13 This concept of help-seeking behaviour in children is important. Help-seeking behaviour is a core part of child development, where children learn over time how to seek help, get validated for that help-seeking behaviour and learn who can be trusted. It is a developmental task which develops over time and is supported by the response of parents/adults. This starts in babyhood when a baby cries and someone responds. Children who are abused, neglected or who receive inconsistent care over time are likely to have under-developed help-seeking behaviour or are actively discouraged or prevented from seeking help through threats, intimidation, or suggestions of impact on family.

3.14 The research evidence[v] suggests that children will 'test out' the response of professionals before making more serious disclosures of harm. It is essential that in a child-centred system, children's concerns are listened to and responded to. Research and reviews of safeguarding systems and processes also highlight that children and young people often receive little feedback about the action taken when they raise concerns about abuse with professionals. This can leave them feeling that their concerns were not heard, valued, or responded to. It can undermine their trust and confidence and prevent further help seeking behaviour. Children and young people need feedback and debriefing, particularly when their help seeking behaviour appears to end in no formal action being taken. They need reassurance that professionals have understood their worries, heard their concerns, and are prepared to take impactful action to address them.

3.15 There is often too much focus on what cannot be achieved because of procedural and evidential barriers, as opposed to what could be done to acknowledge harm, and action that could be taken to increase safety and address wellbeing.

Key learning Points:

- Children need to be enabled and supported to talk about child sexual abuse.
- Their help seeking behaviour needs to be responded to positively.
- Careful thought needs to be given to how 'no further action' from any agency is communicated to a child or family. The concern is that this can suggest lack of belief in what is being said and children do not feel heard.

- When children share concerns and then retract them, this requires appropriate professional analysis to consider what this means in the context of the child's needs and circumstances.

What needs to be done about this and work already under way.

The safeguarding children's partnership developed a briefing about the early learning from Isaac and his family's circumstances. This was sent to all appropriate agencies within the partnership with the expectation that it would be circulated to frontline professionals and their supervisors. The expectation was that each agency/team would develop an approach to discussing the findings with their practitioners.

A 7-minute briefing was developed focussed on communicating with children about child sexual abuse, with a link to resources and training materials[25]. This has been circulated to all agencies who have disseminated to front line practitioners.

The Local Authority has conducted a multi-agency audit of cases stepped down from CP to CiN to seek insight and assurance regarding the issues raised in respect of Isaac are not a wider concern. This has been completed and is due to be shared with the Performance and Quality Assurance Subgroup and Executive with recommendations.

All these actions are part of the Action plan for the review and the progress and impact will be monitored by the Learning and Improvement Subgroup and the Executive group.

Theme 2: The Immediate response to sibling sexual abuse and harmful sexual behaviours.

3.16 Children's sexual behaviours exist across the continuum from developmentally appropriate or expected behaviour (in the context of age and stage of development) through behaviours that are problematic or abusive[vi]. When Isaac made the first disclosure of sexual harm by sibling 1, it was

[25] 1. Signs and indicators of child sexual abuse | CSA Centre

2. Communicating with children | CSA Centre

3. Supporting parents and carers | CSA Centre

4. Managing risk and trauma after online sexual offending | CSA Centre

5. Sibling sexual abuse and behaviour | CSA Centre

6. Safety planning in education: A guide for professionals supporting children following incidents of harmful sexual behaviour (csacentre.org.uk)

7. Intra-familial child sexual abuse | CSA Centre - Key messages from research

8. Sibling sexual abuse: A knowledge and practice overview (csacentre.org.uk)

9. The CSA response Pathway (csapathway.uk)

10. Contact the Stop It Now! child sexual abuse helpline - Stop It Now

12. Responding to a Child's Disclosure of Abuse | NSPCC Learning (youtube.com)

13. NSPCC TV ad, 'Say Something' 60 SEC (youtube.com)

important that this was assessed across this continuum to ensure appropriate action could be taken to address immediate risk for both children and respond to their needs and the needs of the whole family. It is expected that the response would be guided by the Greater Manchester procedures for Harmful Sexual Behaviours Presented by Children and Young People[26].

3.17 Isaac's first disclosure related to the sharing of pornographic material and sexual images of sibling 1. Sibling 1 offered Isaac money not to tell anyone. When interviewed by the social worker, sibling 1 gave a different story, indicating that Isaac had misinterpreted what was going on. Isaac gave a clear outline that this was not the case. All these factors suggest a power difference, some active grooming and denial which would suggest that sibling 1s behaviour fell between inappropriate and harmful sexual behaviour indicating the need for a strategy discussion. It was decided by the MASH team that a child and family assessment should be undertaken. This was a judgement call that did not take account of all the available information.

3.18 Although a safety plan was put in place, there is little evidence of whether Isaac was asked about other incidents of sexual harm or whether he felt at continued risk. sibling 1's assertion that this had been a misunderstanding was accepted and so the meaning of this harmful sexual behaviour, what might have caused it, what needs this sexual behaviour was meeting for sibling 1 and how to prevent further harm to all children was not fully considered or discussed in the subsequent assessment. In terms of making sense of this incident, identifying the meaning, and considering an appropriate response, there needed to be a whole family response. This means considering the family history, parenting, family dynamics and family tensions. This was all missing from the assessment process.

3.19 The second disclosure from Isaac was that he had been raped by sibling 1. Appropriately there was a strategy discussion. The purpose of any strategy discussion is to consider whether a child is at risk of actual or likely significant harm, to plan action that will keep the child safe and to agree next steps. In the context of sibling sexual abuse, a key decision will be whether an active police response is an appropriate course of action, given that both the child who has been harmed, and the child who has harmed are children with their own needs. This requires careful thought, based on the seriousness of the disclosures and the evidence of coercion and harm. It is the role of professionals at the strategy discussion to consider what is in the best interests of each child. Where the child who has harmed is not related to the child who has been harmed there will be separate strategy meetings to address the appropriate course of action. This is more complex in the context of sibling sexual abuse and care should be taken to consider the needs of each child separately, and then in the context of family dynamics and relationships. It is not clear how much this happened for Isaac and sibling 1.

[26] 5.11.3 Harmful Sexual Behaviours Presented by Children and Young People (proceduresonline.com)

3.20 If it is agreed a police investigation is required, joint child protection enquiries[27] should be conducted between the police and children's social care. What is key, is that at the strategy discussion thought is given as to how they will work together and communicate through this process, including sharing information about how best to protect the child and maximise the potential for any necessary criminal action. There is little evidence of close working relationships in this situation.

3.21 It is not clear why, but the strategy discussion decided that Isaac would be asked what he wanted to happen next. There was no discussion about who would talk to Isaac about the medical examination and the ABE/VRI. Children will always have anxieties about these processes and how this will be responded to will need careful thought, particularly in the context of trauma and learning needs. It was agreed that there would be a joint police/social worker visit. This was appropriate and was an opportunity to explain to Isaac what would happen next. This interview was delayed due to Isaac's distress on several occasions and would ultimately not take place. So, he was not told about what a police investigation would involve, or the role that the ABE/VRI or medical would play. He was not fully making informed decisions as a 10-year-old from this point onwards. The issue of both his parents saying they did not want a police investigation could have been discussed. It is not clear they understood what the decisions or processes were.

3.22 There was an undue emphasis on the medical examination, without the purpose of it being clear. Isaac had made disclosures of non-recent sexual abuse. A medical examination would have served to ensure he was physically well and there were no medical concerns. It may have provided some evidence of sexual harm. It may not. The purpose of it was not made clear to Isaac or his parents[28].

3.23 Sibling 1 was not interviewed and none of his devices were seized or reviewed. The focus was on Isaac's ambivalence and worry about the possibility that his sibling would go to prison, and it was agreed that there would be no further criminal action. This narrative, that the reason that no police action was taken was due to Isaac not agreeing to be interviewed or medically examined appears in all the child protection reports and child in need plans. There was no discussion about whether Isaac understood this, knew what he was or was not agreeing to. If he were to come back and review his records in the future, he would be forgiven for believing that it was his fault that no further action was taken. The extent to which he felt that at the time is not known, but it would be a heavy responsibility for a 10-year-old child. When Isaac made a further disclosure 10 months later in 2023, once

[28] See the Centre of expertise on Child sexual abuse guide to medical examinations Medical examinations | CSA Centre.

again the focus was on whether he wanted any criminal proceedings to go forward. This was not appropriate.

3.24 In March 2022 Isaac also disclosed that sibling 2 had sexually abused him to his school counsellor. This information was shared with children's services and when seen he retracted the disclosure. This was accepted at face value, and this disclosure was not revisited. There are many barriers to children talking about sexual abuse. It is not surprising that they often retract concerns. It is extremely rare for children to report sexual abuse when it is not true. It is very common for them to worry about the implications for them and for others if they tell and to withdraw the disclosures. The professional tendency to believe the retraction, rather than the disclosure is a key feature of other LCSPR's. Children need to be given further opportunity to talk about possible abuse after the retraction. This did not happen for Isaac. It would be another 10 months before he felt able to talk again about the sexual abuse by sibling 2.

3.25 There was no discussion of the Criminal Injuries Compensation Scheme (CICS) (2012)[vii]. This scheme seeks to financially compensate victims of violent crime. A child or young person may be eligible if they have been subject to a physical attack, threats against the person which caused fear of immediate violence or sexual assault to which the child did not consent; these incidents **must** have been reported to the police, no matter how long ago they took place. The Criminal Injuries Compensation Authority provides advice about eligibility. This is an important process in the context of how few disclosures of sexual harm progress to charging decisions or court, let alone a prosecution. The criminal injuries scheme can be a way of ensuring children feel they have been heard and believed.

3.26 All the professionals who worked with Isaac were informed they could not talk to Isaac about sexual abuse whilst a police investigation was ongoing. The police decided that there would be no further action in April 2022, and this was formally agreed in June 2022. Yet this belief that the sexual abuse could not be discussed persisted and moved into a belief that it would be the SARC counselling where sexual abuse could be discussed, and for anyone else to discuss sexual abuse would interfere with this work. Isaac must have thought he had not been heard or believed.

3.27 The professionals who attended the workshop held to discuss barriers and enablers to addressing sexual abuse told the review that this is a common misconception. They are often told they cannot talk to children about sexual abuse whilst a police investigation is ongoing, or specialist support is planned.

Why does it matter?

3.28 The biggest mediating factor[viii] for healing after child sexual abuse is for the child to be heard and believed, by their parents and family primarily, but also by professionals. It takes courage to talk about sexual abuse and this initial response should demonstrate a professional commitment to find out what has

happened and ensure an appropriate response which demonstrates that concerns have been taken seriously. It is not appropriate to suggest that children are responsible for deciding what the appropriate action is. This was what happened to Isaac. Exacerbated by the early communication (and it is unclear where this came from) that professionals were not allowed to talk with Isaac about the sexual abuse whilst the police investigation was ongoing. This was not an accurate outline of the current guidance. This will be addressed in the Theme below on addressing impact.

Key learning Points:

- There emerged for Isaac some uncertainty about the threshold for action regarding concerns of sibling sexual behaviour. The threshold needs to be clarified.
- There is also confusion about the criminal justice response to sibling sexual abuse and the role of the victim in being the decision makers in acting. The criminal justice response to sibling sexual abuse needs to be clarified.
- Thought needs to be given about how 'no further action' in criminal justice processes is communicated to children and their families. It is important that children understand why it is not always possible to take action.
- The confusion about whether professionals can talk to children about sexual abuse whilst criminal investigations are ongoing needs to be addressed. This will also include the ability to provide support and therapeutic impact. There remains a belief that these need to be halted. The CPS guidance makes clear this is not the case.

What needs to be done about this and work already under way.

A partnership communication was sent to all appropriate agencies within the partnership to highlight accurate information about appropriate communication with children about child sexual abuse when police investigations are ongoing. This includes challenging perceptions that communication, support, and therapy cannot be provided. This has been disseminated to all front-line staff.

The Education Psychology Service have developed specific training for schools in relation to harmful sexualised behaviour. The training aims to promote healthy relationships and sexual development and reduce risk at an individual, group and whole setting level. It supports schools and settings to identify harmful sexualised behaviour, assess individual pupil need and provide ways to appropriately respond in a school setting. The training utilises the latest national guidance for schools and wider professionals. It provides a model policy for schools and a toolkit that pulls together national evidence-based resources to support school staff in meeting early need.

The Local Authority have conducted a review of children referred into the MASH for concerns regarding child sexual abuse and have conducted a deep dive of cases. This has come up with recommendations for action including some changes to the pick list to Referrers into The Portal, the use of professional curiosity and hypotheses

to explore in more detail concerns around child sexual abuse. This deep dive approach is ongoing.

Action:The front door should consider using the Child Sexual Abuse Centre, Signs, and Indicators toolkit as a way of enhancing scrutiny for children about who there are concerns of child sexual abuse[29].

Action: This work undertaken by the front door needs to include a review of thresholds for action when there are concerns about sibling sexual abuse.

Action: There needs to be further consideration of the threshold for police and children's social care action when there are concerns about sibling sexual abuse. This is not included in the Greater Manchester guidance for Harmful Sexual Behaviours.

Action: The police will need to consider their routine response to communicating that they are planning to take 'no further action' to children in a way they can understand and validates them for having sought help.

Action: There needs to be guidance produced about the Criminal Injuries Compensation Scheme (CICS) (2012). Where this should be placed requires some thought. The Centre of Expertise on Child Sexual Abuse has launched a Child Sexual Abuse Response Pathway which a number of pilot areas have incorporated into their child safeguarding procedures. This would address the issues about Criminal Injuries Compensation. There is work ongoing to consider whether the Response Pathway could be incorporated across Greater Manchester. These discussions are at their earliest stages and progress will need to be reported to the Learning and Improvement Subgroup and the Executive Group.

Theme 3: The longer-term support response to sibling sexual abuse.

Support for the child who has been harmed.

3.75 Support in the aftermath of sexual abuse is essential for children to make sense of what has happened to them and to start the process of healing.

Keep safe work.

3.30 The child and family assessment concluded that Father needed help to manage the behaviour of Isaac, sibling 1, and sibling 2. There was also a proposal for direct work with both Isaac and sibling 1.

3.31 Early direct work took place with Isaac in the form of keep safe work[30]. The aim was to help Isaac understand healthy relationships, issues related to consent, distinguishing appropriate and inappropriate sexual behaviour and to recognise the grooming process. Keep safe work is an important preventative strategy which helps children to recognise harmful sexual behaviours and feel

[29] Signs and indicators of child sexual abuse | CSA Centre

[30] This is preventative work with children to help them understand things like consent, reporting abuse and feeling able to respond if an adult or child behaves in an inappropriate or sexually harmful way. It is education in approach.

confident and validated to seek help when they are uncomfortable with the behaviour of adults or peers. Despite the usefulness of this work, caution is required in the context of concerns that a child may already have been sexually abused. Keep safe work which is not done carefully can imply to the child:

- It is they who is responsible for keeping themselves safe, as opposed to this being the responsibility of the adults around them.
- It is their lack of knowledge and understanding that caused the abuse in the first place, rather than placing responsibility onto the person who is harming the child.
- It can provide false security that this work will automatically keep the child safe from sexual abuse in the future, rather than this being the task of adults to help keep them safe.

3.32 Once this keep safe work was completed, there was no further direct work undertaken with Isaac due to the lead social worker being away from work. School put in place a great deal of support for Isaac. Counselling was provided and 1:1 support by school. This was to help him to manage to be in school. The school counsellor was told that she could not discuss sexual abuse with Isaac whilst a police enquiry was underway.

3.33 A referral was made to Sexual Assault Referral Centre (SARC) for specialist sexual abuse counselling and support. Isaac would be on the waiting list for this for almost a year. This delay was discussed in the core group meetings and review conference that took place. There was increasing evidence of Isaac's distress, and awareness that the lack of support was exacerbating this, but there was no action taken to address this gap in service. This action could have included an escalation to the commissioner of the service or the seeking of other sources of support. In the meantime, he was provided with continued support at school. There was no other support in place.

3.34 It was agreed there would be a referral to CAMHS. There was an appointment in March 2022. CAMHS considered the importance of the child sexual abuse disclosures in preparation for the first assessment. They were then informed that there had been a new disclosure and that they could not discuss this because of the investigative process. Isaac was assessed as having no mental health concerns. In response to father's worries about ODD/ADHD a supporting letter was sent to the GP to arrange an assessment, alongside a referral to counselling. CAMHS were then informed by the social worker that a referral had been made for specialist sexual abuse counselling and it was agreed there was no need for 2 referrals.

3.35 In the summer of 2022 Isaac's primary school became increasingly worried about his distress, manifesting in complex behaviours, aggressiveness, and violence; they were concerned about their ability to support him safely. They submitted a referral for an EHC assessment to fund ongoing support. This was heard by the panel, who were made up of education professionals. They were not provided with any information from children's services and again it

was believed that information about the sexual abuse could not be shared because of the police investigation (this had already concluded). The EHC application was declined due to insufficient information of Isaac's support needs. Isaac's circumstances were considered at the exceptional cases panel, and again it was decided that the school should continue with its support offer.

3.36 School tried hard to enable Isaac to remain in school, but in November 2022 it was agreed that he would attend the pupil referral unit (PPU) for a period of time. This was to enable him to have smaller classes and more individualised support. Despite the PPU working hard to support Isaac, this move was not successful.

3.37 It was only in January 2023 that the EHC assessment was agreed, and specialist education provision provided.

3.38 Isaac's junior school were a consistent source of support and care across the timeline of this review. They funded in-house counselling and extra support to enable him to be in school. This was critical to his wellbeing. Yet this work was not acknowledged in the CP plan and was not included in the child in need work. This was also true of the PPU who put support in place.

3.39 Over the time under review, Isaac received very little support to help him make sense of the sexual abuse and the trauma he had experienced. This was due in part to a pervasive belief that it was not possible to talk about sexual abuse because of ongoing police investigations, and the sense that only a specialist agency could provide the right support.

Support for the child who has harmed.

3.40 The plan for sibling 1 was for there to be an AIMS2 assessment. This took some time to organise. In the meantime, despite there being a child and family assessment and a child protection inquiry there was little exploration of the family background, or a consideration of the need to try and understand what were the factors that might have caused the harmful sexual sibling behaviours.

3.41 When the AIM2 assessment was completed it provided a clear outline of the risk that sibling 1 posed to other children, which was high, and the level of supervision he would require. As sibling 1 was living with his mother, it was expected that she would provide this supervision. There was no assessment of her parenting capacity or capacity to provide this supervision. There was no exploration of past and present family relationships, or earlier difficulties mother had experienced, and little was known about these. These were all necessary to ensure that sibling 1 could be appropriately supported and that other children were kept safe. Father was also expected to provide supervision when sibling 1 stayed with him. There was no assessment of his parenting capacity, no understanding of previous relationships and what might help with the safety plan and what might hinder it. The assumption was that both Mother and Father could support sibling 1 and manage the safety plan.

There is no evidence that they did not manage this, but both reported that overall, there was an impact on their physical and emotional health; a point picked up in the section on support to non-abusing parents.

3.42 Sibling 1's school were told they could not see the AIMS 2 assessment, despite needing to provide a safety plan for him to be in school. Their role was not acknowledged in the child protection or child in need process.

Why does it matter?

3.76 Identifying child sexual abuse and providing a supportive response can reduce any long-term adverse impact for children. If responses are not supportive this can compound adverse impacts on mental health and emotional wellbeing, including by instilling shame and guilt which can last into adulthood. Conversely, non-judgemental, and trauma-informed responses can improve victim-survivors' ability and willingness to seek support and disclose further.

Key learning Points:

- Providing keep safe work in the context of concerns that a child has already been abused needs careful thought and caution.
- There needs to be more readily available support for children who have been sexually abused. It is not reasonable for them to wait for over a year. Solutions must be found.
- Although specialist support is important, this must not get in the way of routine direct work where children can be enabled to talk about their worries, reflect on their feelings and think about what has happened and what the impact is on them.
- The work of schools to meet the needs of children who have been abused should be included in child protection and child in need plans. Without this their child focussed work goes unnoticed or taken for granted.

What needs to be done about this and work already under way.

The Safeguarding Partnership commissioned a multi-agency audit of the professional response to child sexual abuse. This has concluded with recommendations about recording, training, strategy discussions, use of escalation policy and active commissioning of additional sexual abuse support for agencies across the borough. This is in the process of being actioned.

Action: This audit activity picked up many of the issues for Isaac, but the findings of this review will need to be factored into the action plan including response to children retracting child sexual abuse, guidance regarding joint police/social work enquiries, communication to children about 'no further action' decisions, appropriate use of keep safe work, assessments of siblings sexual abuse and appropriate safety planning and support for non-abusing parents.

Theme 4: Understanding and responding to the impact of sexual abuse.

3.44 The impact of the child sexual abuse that Isaac was subjected to by his siblings was apparent from his first disclosure in school in November 2020. The headteacher noted that he was visibly shaken and distressed. They continued to see the impact manifest in his complex behaviours and aggression. They responded with care and support and kept him in school, despite the challenges.

3.45 There was an appointment at CAMHS in March 2022 where father talked of concerns about Isaac's behaviour. CAMHS had been told just before the appointment that the recent allegation of sexual abuse could not be discussed. Father was concerned about Oppositional Defiance Disorder or Attention Deficit Hyperactivity Disorder and a referral to the GP for an assessment was facilitated at his request. Isaac was then seen by the community Paediatrician with the same concerns from father and a plan to progress an assessment of these needs. The impact of sexual abuse on Isaac was lost and the focus was on him having complex needs.

3.46 The distress caused by the impact of child sexual abuse can manifest in many ways. For Isaac the manifestation was in the form of anger, aggression, feeling out of control, not being able to regulate his emotions and anti-social behaviour. This led to action by the police, where there were talk of charges being brought, and being brought home on one occasion in handcuffs. The contradiction to his own disclosures that he had been a victim of crime with almost no perceptible action will not have been lost on him. It would have undermined his sense that he was the victim of harm, something that got increasingly lost along the way.

3.47 The core groups discussed Isaac's behaviour, not the causes of the behaviour and in the child protection plan, it was recorded that '*Isaac continues to display concerning behaviour that is not deemed to be solely due to abuse. He had attachment/behavioural issues before this*'.

3.48 There was a lack of acknowledgement that this was a child who was saying he had been sexually abused at the age of 6/7 when he would have not been able to understand what was happening or to process this. Isaac's distress, often in the form of anti-social, aggression and violence were not always acknowledged, and he was not helped to make sense of it.

Why does it matter?

3.49 Child sexual abuse is a traumatic event which can cause a negative impact on a child's mental health and wellbeing, including anxiety disorders, depression, eating disorders and disturbances, sleep disruption and insomnia, and dissociation[ix]. It is also associated with adverse physical health conditions in childhood, some of which may be interconnected with the mental health impact of abuse. For many these adverse consequences last into adulthood, and for some into old age.

3.50 Children often do not understand the connection between the abuse they have been subjected to and the feelings, worries and trauma symptoms that they experience. These trauma symptoms can reinforce messages from those that harmed them that there was something wrong with them, or they can feel that they have been inherently damaged. Responses which do not recognise the impact as trauma symptoms and treat them in isolation from the trauma can reinforce these feelings; children need help to understand what they are experiencing is a trauma response focused not on "what is wrong with you?" but "what happened to you?" Professionals also need to let the child know that if they are experiencing a trauma response and painful feelings, this will take some time to go away but will lessen and eventually heal over time. Harm, however, is not inevitable[x]; if the right support at the right time is provided it makes a difference.

Key learning Points:

- Child sexual abuse will always have an impact on children. They are dealing with trauma. If we do not help them understand the link between what has happened and the difficulties they are experiencing, they can internalise a sense of 'something being wrong with them'. They need help to understand trauma responses.
- Professional help to address the impact of child sexual abuse needs to ensure that children understand that we recognise those trauma responses and don't drift into talking about problematic and complex behaviour which needs a treatment approach, with contextualising the sexual abuse.
- Children do heal from sexual abuse, but they need trauma focussed services to do so.

What needs to be done about this and work already under way.

Work is underway by the ICB to review SARC waiting times, the current support offer for children who have been impacted by child sexual abuse, the work of the CHiSVA, therapeutic pathways and flow between CAMHS and SARC in terms of referrals for sexual violence and abuse. Work on all of these issues will be ongoing and identified as short/medium/long term in a work plan to be shared amongst the established working group and the Learning and Improvement Subgroup and Executive with recommendations.

Whilst this work is being undertaken, an escalation pathway is to be developed to support cases such as those raised for Isaac and additional funding streams being sourced via both ICS and national routes. Where waiting times are excessive and a child is suffering significant trauma as a result of their sexual abuse, the partnership can commission a private package of support from a suitably qualified practitioner.

As part of the audit activity action plan, work needs to focus on the overall local offer for children who have been sexually abused. This work will also need to think about support to families and non-abusing parents (see next Theme).

Theme 5: Support for non-abusing parents and the whole family

3.51 Research[xi] suggests that finding out that a child in the family has been or may be being sexually abused has a profound impact on non-abusing parents and the whole family. This is particularly apparent in the context of sibling sexual abuse. The recent national sibling sexual abuse research project survey and interviews[xii] highlighted how sibling sexual abuse was felt to 'destroy the family'. Parents and carers were often faced with what they termed the 'double dilemma' of trying to support both of their children in terms of the child that has harmed and was harmed.

3.52 Father did share this dilemma with the reviewer, that he felt torn between the children, how to support their different needs and that the whole family had been 'torn apart'. These feelings are not unusual, and both father and mother needed help to understand this.

3.53 Initially there were concerns that father had known about the abuse and not shared these concerns and even asked Isaac and sibling 1 to keep quiet. Appropriately this was discussed sensitively with father and mother during the assessment process in November 2021 and the child protection enquiry in March 2022 Father was able to clarify that his knowledge of what had happened was recent, that he had asked Isaac and sibling 1 not to discuss these disclosures with their friends due to concerns about community retaliation. It has taken both parents a while to comprehend what has happened and their current position is that Isaac has been sexually harmed and both sibling 1 and sibling 2 were responsible for this. The evidence suggests that most parents struggle to come to terms with sibling sexual abuse, and they need advice, knowledge, and guidance to understand and make sense of this. There was insufficient advice provided to father or mother about this. They needed more help to make sense of this early in the process. They also needed to be kept more fully informed about the police investigation, something they continue to feel uncertain about.

3.54 Support needs to be in place for parents and the whole family. This requires a good understanding of family history, relationships, tensions, and pressures. There was very little attention paid to this for this family. The absence of this meant that safety could not be assured through the management of a safety plan and meant that there was a lack of attention to how both parents and other family members were able to help and support all three children. Family history was also missing, including vulnerabilities.

3.55 The initial child and family assessment highlighted that father needed support to manage the behaviour of Isaac, sibling 1, and sibling 2, and although this behaviour was not seen in the context of the existing trauma, this support was indeed necessary. The older boys were using cannabis and there was evidence that they were struggling to regulate their emotions at school, evidenced through aggression, violence, and cannabis use. There was no reflection about why the children were struggling, but father and mother needed support to manage their children's emotional needs and make sense of them. The escalation to child protection processes meant that in March 2022 this support was not provided, and despite child protection planning and child in need processes there was no further support discussed or agreed for either parent or the whole family.

3.56 There was evidence that father was experiencing poor physical health, including 2 heart attacks and some concerns about his mental health. Less is known about how mother was coping. She reported during the final child protection review conference that her physical and emotional health had deteriorated. There was no plan developed to address this.

3.57 There was nothing in the child protection plan or child in need plan about what these parental challenges might mean in the context of how they could support Isaac, sibling 1, and sibling 2 and how to support their own needs.

3.58 Isaac's school stands out as the agency who provided father with most support and care. The headteacher spoke with father on most days, listened to his worries and concerns and sought to help him understand what was happening. This was good practice. A support package for the parents and wider family needed to be built into the child protection planning and child in need processes.

Why does it matter?

3.77 Research has highlighted the need for support and advice for non-abusing parents. In the context of sibling sexual abuse to help manage family dynamics, to create safety plans, to address stress, poor mental health, and ill health and to help them understand what has happened and what they need to do to support the child who has harmed and the child who has been harmed. Parents and the wider family are key to healing in the long term.

Key learning Points:

- Sibling sexual abuse has a profound impact on the whole family. This needs to be recognised and responded to.
- Assessment needs to focus on family history, vulnerabilities, concerns about previous neglect, domestic abuse, and family relationships to understand the dynamics that are going to make family healing and recovery more difficult and undermine the ability of adults to provide safety and support. Both are critical to children.

Theme 6: Responding to the potential signs of child criminal exploitation[31].

> *It all depends on where you grow up (not just parenting) cos when you step outside of your home, there are other people there….and you get pressured into doing bare stupidness. Quote from young person. Firmin 2023[xiii]*

3.60 Alongside concerns of sibling sexual abuse, Isaac also shared with the school counsellor that he and sibling 2 were linked to gang activity in March 2022. This included moving drugs around for money. He also reported that at the age of 10 years old this had led him to trying cannabis and other substances. The counsellor appropriately told Isaac that she would need to share this information with other agencies. Isaac said that he was worried about what his father would say and said she had misunderstood what he had said.

3.61 The counsellor made a referral to children's services. This referral was then followed up with Isaac's disclosure of rape against his sibling 1. A strategy discussion was agreed. This strategy meeting focussed on the concerns about sexual abuse, as opposed to criminal exploitation, but there was agreement that further information about criminal exploitation needed to be sought.

3.62 A week after the strategy discussion Isaac was seen at CAMHS. During the meeting Father noticed a picture on Isaac's phone where he was holding a £20.00 note. Isaac said this was earned by '*doing business'* and father said he was concerned that Isaac was involved in drug dealing. The CAMHS practitioner made a referral to children's services. At the same time there was information from a police home visit that Isaac had a knife hidden in the wall of his bedroom, without a clear explanation of why this was the case. There was a discussion about whether a further strategy discussion was needed, and it was agreed that members of the safeguarding team would be invited. This did not take place, despite the concerns. The lead social worker made a referral to the complex safeguarding team. Isaac and sibling 2 were discussed at the daily exploitation meeting on the 14 March 2022, and it was recommended that the social worker would be provided with specialist resources to undertake further work with Isaac and sibling 1. This work never happened. It is not clear why.

3.63 The initial child protection conference took place on the 23 March 2022 and part of the child protection plan was for the lead social worker to complete direct work with Isaac and sibling 1 about criminal exploitation and grooming. This work never took place, and the lack of progress was not challenged within the context of core groups, child protection conferences or child in need meetings.

[31] Child exploitation is when someone uses a child for financial gain, sexual gratification, labour, or personal advantage. Using cruel and violent treatment to force a child to take part in criminal or sexual activities. The exploitation of children can take a number of different forms and perpetrators may subject children and young people to multiple forms of abuse at the same time, such as criminal exploitation (including county line 2022s) and sexual exploitation. The Home Office, 2019 (updated 2022).

3.64 Ultimately, there was an acceptance that the counsellor had misunderstood what Isaac had said. This was another version of 'retraction'. There was a lack of reflection that there was needed to be a more nuanced understanding of the likelihood that Isaac and sibling 2 were being drawn into the early stages of criminal exploitation. sibling 2 was seen as moving into adulthood and there was little attention paid to his needs and circumstances. For much of this review he was on the periphery of understanding of what was happening.

3.65 There was no discussion with neighbourhood police about what drug related activity was going on in the estate that the family lived on. Isaac would often go missing and was engaged in anti-social behaviour. There were few questions asked about the context for this, with the focus being on him. All three of the boys used cannabis. This was a concern because this caused tensions when father tried to put boundaries on sibling 1 and sibling 2's cannabis use. This led to police call outs. This issue of likely early signs of connections to gang activity and criminal exploitation was never fully explored or understood. Father was clear when the reviewer met with him that this was a significant risk on the estate they lived on and led to him recently moving house.

3.66 In December 2022 the PPU that Isaac attended had significant concerns about him accessing inappropriate material including extreme racism and a fascination with Nazism. His attitudes also indicated concerns about harmful racist views. Appropriately this was shared with agencies and specialist agencies dealing with hate crime, including the Prevent team. These concerns were not linked to possible gang affiliation and were not taken seriously by the wider safeguarding network. They were not included in the child in need or child protection planning processes.

Why does it matter?

3.67 Nationally it has been hard to establish how many children are subject to criminal exploitation[xiv], but what is clear is that many children are at risk of extra-familiar harm and the numbers are growing. Children who are exploited are often those who have previously been abused, have disabilities, complex needs, mental health concerns, fragmented family relationships and poor school attendance. These are all risk factors which make criminal exploitation more possible in the context of grooming but are not necessary factors. Contextual safeguarding makes clear the need to understand the context in which children live, and to understand the risk factors inherent in these places, rather than focusing on the characteristics of children.

3.68 Criminal exploitation causes serious harm to children[xv]. It needs to be taken seriously, particularly in the likely early stages, and addressed and stopped.

Key learning Points:

- There needs to be a more preventative approach to the early indicators of gang affiliation in its widest sense and links to drug dealing/criminal exploitation.

What needs to be done about this and work already under way.

The work of the Local Authority in the context of criminal exploitation has been subject to internal and external review. The peer review process in 2023 provides reassurance of the effectiveness of the current approach and in 2022 the Ofsted Inspection identified responding to criminal exploitation as an area of strength. An internal audit took place in 2022 and found that children were being effectively protected from harm.

There is now a refreshed strategic group overseeing the response to child criminal exploitation. In December 2023 the integrated Wigan Safeguarding Adolescents service was launched with an enhanced adolescent support team, a focus on early intervention and support all underpinned by Greater Manchester Safeguarding Adolescent Framework based on a trusted relationship approach. This work will be subject to scrutiny by the Strategic Complex Safeguarding Subgroup.

Theme 7: The role of routine child protection processes in meeting the needs of children.

3.69 This review has focused on concerns about sibling sexual abuse, and the complexity of working to address these concerns. Routine safeguarding processes are in place to ensure that actual or likely significant harm is identified, safety is provided to children, child protection plans are developed to respond to the need for safety and to address changes needed and support to be provided.

3.70 Theme 1 has already identified that there was inconsistency in the use of strategy discussions for Isaac, sibling 1, and sibling 2. A strategy discussion was not convened when there were early concerns about harmful sexual behaviours in November 2021, evidence of criminal exploitation in March 2022 and a further disclosure of sexual abuse by Isaac in March 2022. This meant that these concerns were not addressed going forward and were not in the mindset of professionals or prioritised in planning.

3.71 The strategy discussion in March 2022 relating to Isaac's disclosures of rape by sibling 1 did lead to child protection enquiries and an initial child protection conference. At the conference an outline child protection plan was developed. This included:

- Counselling for Isaac from SARC.
- Social work referral for psychotherapy for Isaac from CAMHS.
- Sibling 2 to attend CAMHS support (in the area he was now living).
- Direct work to be completed with Isaac and sibling 2 about criminal exploitation.

3.72 Regular core groups[32] were held. Their role was to ensure that the right child protection plan was in place and that the key elements of it were being

[32] The core group is a small group of professionals and family members who meet after an initial child protection conference. The aim of a core group meeting is to develop the outline child protection plan. Regular core group meetings look to make sure the work set out in the plan is carried out, and changed as necessary. The core group is usually led by the child's social

delivered. It is notable that the support provided by school was not acknowledged in the child protection plan. This work was invisible. The core group could have endorsed the need for the EHCP and ensured that appropriate evidence was provided. The core group could also have challenged the lack of progress on this.

3.73 It is striking the extent to which most aspects of the child protection plan were not delivered upon, and that this was not challenged in either core groups or the review child protection conferences held in June 2022 and November 2022. This referral to CAHMS for Isaac was not made because there was a belief that this could only be actioned when the SARC counselling was complete. This was never discussed with CAMHS. The absence of progress of the direct work by the social worker was accepted, and the absence of this not challenged going forward. The fact there was nothing in place to support the parents or the family was accepted. The lack of progress of the SARC work was also accepted. This was despite it being a core aspect of the child protection plan. The chair of the child protection conference could have challenged this, so could members of the core group, including the lead social worker. The headteacher did challenge the lack of progress and raised it with core group members. She was left to take this challenge outside of these meetings.

3.74 The core group and child protection conferences accepted the narrative that it was up to Isaac whether criminal processes went forward, despite his age. There was no discussion about how to help him make sense of criminal processes and what would help. The core groups focussed on what was happening in terms of incidents, not sufficiently on what the needs of Isaac, Sibling 1 and sibling 2 were and what progress was being made on the plans to address those needs.

Why does it matter?

3.78 The child protection plan is intended to address the needs of children who are considered to have suffered or likely to suffer significant harm. These plans are the road to safety, change and recovery for children. The core groups and review conferences are the opportunity to review progress, check whether the right plans are in place and whether children's outcomes and safety are improving. The core groups and review conferences for Isaac did not consider the lack of progress of the plan, notice gaps within it and seek to address both. The lack of this leaves children's safety and outcomes at risk.

Key learning Points:

- The role of child protection conference chairs' in ensuring that child protection plans are actioned and fit for purpose is critical. It did not happen for Isaac or his family.

worker and will include other people, such as a health visitor, teacher or GP. These will be the professionals who work most closely with the child and know them best.

- Core groups are the next line of defence on advocating for children, ensuring that child protection plans meet their needs and are actioned. They have a role in challenging drift and delay. The role of core group members was not clear here.

What needs to be done about this and work already under way.

The Safeguarding Partnership is in the process of producing refreshed multi-agency guidance about the professional responsibilities within core groups, their aim and process for escalation if concerns exist. Given the important role of core groups to develop child protection plans, this guidance will emphasise the importance of school and education activity as part of plans. The guidance will re-emphasise the effectiveness of plans to respond to children's needs, ensure that plans are implemented in a timely, child centred way and lack of progress responded to.

The briefing has been produced and the guidance will be issued to professionals through existing networks and several bitesize briefings (January/ February 2024)

Recommendation 1.

There is a lot of action that has already been started by the Safeguarding Children Partnership and a lot of work in process. This review recommends that all this activity be brought under one strategic umbrella, and a strategic response to improving the response to child sexual abuse developed. This would incorporate much of the planned work and proposals for action in this report.

References:

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[viii] The impacts of child sexual abuse | CSA Centre

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[xii] Sibling sexual abuse project | SARSAS

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[xiv] Rising tide of child exploitation | The Children's Society (childrenssociety.org.uk)

[xv] Child exploitation disruption toolkit - GOV.UK (www.gov.uk)