Child Safeguarding Practice Review
Family 1
child sexual abuse and harm

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Introduction

1. The Shropshire Safeguarding Community Partnership (SSCP) agreed to undertake a local Child Safeguarding Practice Review (CSPR) to consider practice and systems in working with children and their families where there are concerns that could indicate sexual abuse in the family environment, and its coexistence with neglect. This followed a child in Family 1 being identified in indecent images shared by their stepfather. He appeared to be abusing her in the pictures. When the police went to arrest the man, they had serious concerns about the state of the family home. It was overcrowded, dirty and cluttered. Subsequent assessments have identified that the children in the family have been exposed to emotional harm and neglect, and several of them have alleged both physical and sexual harm.

2. The learning from the consideration of agency involvement with the children and their parents is in the following areas:
   - The co-existence of sexual abuse and neglect
   - The children's place in the system
   - Behaviour as communication
   - Recognising, assessing and addressing the signs of sexual harm and abuse
   - Families that move
   - Professional challenge
   - Considering parental engagement with agencies

The Process

3. Two independent lead reviewers[1] were commissioned to work alongside local professionals from Shropshire to undertake the review alongside a panel of managers and safeguarding leads. The reviewers and the panel worked together to identify the overall learning, and the recommendations included in this report. As well as the completion of this report, further focused work was undertaken specifically in respect of the neglect of these children, and this reflection and subsequent learning has been included in a thematic CSPR on the response to indicators of neglect, titled Child Safeguarding Practice Review Neglect, published on 17/04/2026.
4. The Rapid Review process that preceded this CSPR included the submission of detailed agency chronologies and reflection about the learning identified initially. These and further information shared at the Rapid Review meeting was the starting point for the CSPR. Each agency involved was also asked to provide further reflection on their agency involvement and consider whether any single agency recommendations were required prior to the completion of the review.
5. A face-to-face multi-agency meeting was held with Shropshire professionals who had been involved with the family. The meeting included discussions about this involvement and about the wider systems in which they work. Those unable to attend were spoken to by the lead reviewer in separate smaller meetings. There were some issues with the right people being invited to the meeting. The concerns about this have been raised with the relevant agencies and process learning has been identified to positively impact future reviews.
6. The family are white British. They used to live in another part of the country, moving to Shropshire in 2019. The decision was made by the CSPR panel to consider information shared by the agencies in that area, to recognise the impact of the history on more recent practice, and the particular vulnerabilities of children who move. It was agreed that sufficient information was shared by the agencies in the previous area when the family moved, and that further information would not be sought during this review. Learning has been identified below about the use of that information when considering the needs of the children while in Shropshire, as reflected below. Professionals from the previous area were not spoken to as part of this CSPR as a proportional response to issues more than six years ago, but the learning has been shared with the safeguarding partners there with the expectation that they consider if they need to undertake any further work.
7. The lead reviewers and a representative of the SSCP met with the mother and one of the children, so that learning could be identified from their perspective. The lead reviewers and the partnership thank them for their time and insight.

The Learning

Learning area – child protection issues that reoccur.

[1] Nicki Pettitt is an independent social work manager /safeguarding consultant and experienced lead reviewer. Hannah Bates is a social work manager /safeguarding consultant. They are both entirely independent of the SSCP.

8. The children were on child in need plans when they moved to Shropshire in 2019. They had previously been on child protection plans with concerns about neglect and sexual abuse over a number of years. The eldest child in the family was nearing adulthood and there had been long term concerns about their social and emotional development, and their behaviours to their siblings and peers. There was a view at the time that the move may be positive for the family as the main risk of sexual abuse was thought to be from the father of the older children who was not going to have contact following the move. It was recognised that the neglect concerns may reoccur, and that the child in need plans needed to remain open in Shropshire, which they did for some time following the move. One of the social workers involved from 2019 stated that the risk of neglect was felt to be the main concern and reason for the child in need planning. However, there was a referral made to an agency at the time who provided support to children where sexual abuse may be an issue. (No longer commissioned locally.) There was some work planned, however during the COVID pandemic online support was implemented, which appears to have been difficult for the family to access consistently, and for the children to access independently of the parents.
9. The recognised concern about neglect was appropriate, as it is a child protection concern that reoccurs over time and causes significant cumulative harm to children. This issue is covered in more detail in the thematic review on neglect that the partnership is completing and publishing alongside this CSPR For Family 1, there was evidence that the children had experienced neglect throughout their childhoods, and that their parents had been unable to maintain the long-term changes that were required. The negative impact on their education, mental health and wider wellbeing was and is evident to those who know them well.
10. The ongoing risk of sexual abuse was not robustly considered when the family moved. This was despite indicators that the impact of previous abuse and potentially the risks remained (see below). Records available from the previous area show that there had been allegations of sexual abuse made about mother's current partner who had moved with them to Shropshire in 2013 and potentially in 2016 which had not led to any further action there. At the time there had been a view that as the children had withdrawn their allegations, there was no evidence of harm. This is despite research showing that false retractions are more common than false allegations. It is not known what pressure the children may have been under at the time. There was limited understanding of his risk, as the focus was on the children's father who did not live in Shropshire.
11. The handover between local authorities was not robust, and the social workers who were involved following the move did not read the files from the other area. This mean that some (or indeed much) of the detail would be unknown in Shropshire. The review was told that it is not common practice to travel to other areas to read files, but to rely on the information shared, which is often a summary. Had the children been on a child protection plan at the time of the move, there would have been a transfer in conference. The review was told that often when a child is on a child in need plan there is no notification, and that they must rely on partner agencies such as school or health to inform CSC.
12. There was also limited understanding of how protective the mother was, or consideration of whether she may have been involved in any sexual abuse of the children. There was a knowable history from

the previous local authority that Mother had sent her children to stay with their father just a few months after they had made allegations of sexual abuse against him. Because the allegations had not been proven at the time, CSC did not act when this happened. The national CSPR 'I wanted them all to notice' that considered child sexual abuse within the family environment (2024) found that agencies frequently disbelieved children, misunderstood or minimized risk, and applied criminal standards rather than safeguarding thresholds. This was partly due to professional disbelief, a skills gaps, and a lack of focus on child sexual abuse within the family environment by agencies in recent years.

13. As well as this history of mother not protecting the children, those working with the family needed to consider whether there was a risk of her 'choosing' a new partner who poses a risk of harming her children, after her previous partner had done so. There is some evidence that child sex abuse in families can be a reoccurring harm. Mother's own history of trauma as a child or adult was not known to those involved at the time, and so this was not considered alongside the possibility she may have repeated a harmful relationship pattern. She appears to have been groomed by her previous partner and had not completed any significant work in this area to help her avoid this happening again. The chances of her being vulnerable to other dangerous men needed to be considered and assessed.

14. Mother told the review that her own childhood had been traumatic. She had lived with domestic abuse from a very young age and was sexually abused by a close family member from the age of five. She is very open that she believes that this has left her with 'complex PTSD'. There was a need to know and consider this information when assessing her as a parent. Childhood trauma like this can impact on parenting, including on the ability to form a secure emotional bond with and protect her own children. There is also evidence that a woman who was sexually abused as a child is more likely to choose a partner who is abusive than her peers who have not been abused. This appears to have been the case for Mother at least twice. There is no evidence that any work was completed with her to mitigate this risk. Professionals need to work with the non-abusing parents to assess how protective they will be in the future and the provide advice and guidance in this area, or in respect of support about how to care for a child who has been sexually abused.[2]

Learning area: indicators that sexual harm or abuse may be an issue in a family and recognition of behaviour as communication of trauma

15. There were known physical indicators of poor sexual boundaries in the home. For example, the presence of sex toys that the child accessed, CCTV installed in the bedrooms, and locks on most of the doors (this had also been an issue in the previous authority where the family lived). While the parents had plausible explanations for all of these things, there was a need to be curious about what else could be happening in the home. This required parallel consideration of the behaviour of the children and the quality of the relationships of the family members. Information not known but knowable from the previous area shows that all of the children were showing sexualised (and in some cases sexually harmful behaviour) from a young age.

[2] https://assets.publishing.service.gov.uk/media/67446a8a81f809b32c8568d3/CSPRP_-_I_wanted_them_all_to_notice.pdf

16. The behaviour of one of the younger children was seen as particularly difficult in the years that the family lived in Shropshire, and it is now known that this began when he was in the previous area from the age of around six-years-old). To some extent this mirrored the behaviour of one of the older siblings in the previous area, showing a potential pattern that needed consideration over time. The younger child reportedly often used explicitly sexual language, accessed pornography on the internet whenever he could, frequently masturbated, and behaved in a way that was increasingly sexual towards his siblings, including being found undressed in bed with a younger sibling.

17. When asked about his experience of the professionals involved in his life, the child told the review that the most important thing that they must do is spend time with the child and to hear what they have to say. He said, 'spending five minutes with them is not nearly enough', but that this was his experience of many professionals in Shropshire. He said that giving time to a child was the most important thing any professional can do, and the CSPR agrees. A child needs to trust a worker if they are going to be open about their lived experience. It takes time and consistency to build trust, and to understand a child's needs.

18. Dr Elly Hanson has written a research review called Understanding and Responding to Sibling Sexual Harm and Abuse, which was published in 2024. It states that the issue is of national significance, as sibling sexual abuse is largely 'under-estimated, under-reported and misunderstood'. It is also potentially not seen as being as serious as other forms of sexual abuse. In 2024 the NSPCC described it as 'hidden harm' and 'the last taboo'. Those professionals involved in this review acknowledged that they do not have a lot of experience or confidence in this area of child protection.

19. There was a need to consider why the child was behaving in such a way, and what he was communicating by his behaviour. There was also a need for consideration of what the child had experienced themselves, as sexual abuse had been an issue previously in the family, with adults and siblings being the alleged perpetrators. When a young child (primary school age in this case) shows sexualised behaviour towards a sibling or a peer, it is important to consider whether they have themselves experienced abuse (often called the Cycle of Abuse[3]). The child told the review that children who are being abused or who have seen abuse in their home are likely to be very worried about what will happen if the abuse is exposed. They are also likely to be scared of the perpetrator.

20. It was known that there had been long term concerns about neglect and domestic abuse in Mother's previous relationship, and allegations of physical abuse. These can cause trauma for the child, but the history of sexual abuse in the family environment also needed to be considered rigorously. Mother told the review that she was led to believe that her younger child's sexualised behaviour was 'normal' or a 'phase' or perhaps due to him potentially having ADHD[4]. She now recognises that it was due to what he had observed at home.

[3] Kirkpatrick, D. (1993). Siblings and Sexual Abuse: A Literature Review. Where connections to prior abuse of the perpetrating child are noted.
[4] He was not assessed for ADHD at the time. (Is this right?)

21. Professionals discovered in 2020 that Mother's partner had chopped off one of the older girl's long hair. While it was seen as inappropriate and upsetting for the child, this also needed to be seen as potentially an indicator of abuse, and that it might be sexual. While cutting a child's hair as a punishment is not necessarily a sign of abuse, when it is alongside other concerns it may indicate that the parent is trying to control the child, or to punish or humiliate them. An abuser may also wish to make the child less attractive to others. Now that we are aware of the sexual abuse of the older siblings by the male in the home, this was clearly something that needed more curiosity at the time. The police also informed the review that they would have considered the matter at the time as a potential assault[5] had the information been shared.

22. Dr Hanson's report states the need for in-depth assessments and a 'whole family approach' that is bespoke and modular, when there are concerns that a child in the family poses a sexual risk to a sibling. This must prioritize the safety of the victim child/ren while the harming child's needs are also addressed along with other family members. The report also considers the impact of pornography, which was evident in this case. The review has found that there is a need for all professionals to have more knowledge and support when it comes to working with families where there are indicators of sexual harm and abuse, which professionals in Shropshire recognised as a need for them.

23. In Shropshire Purple Leaf[6] provides advice to professionals but also risk and need assessments for children and young people aged 5 – 18 'who have experienced or been impacted by and/or exhibited inappropriate, problematic, or harmful sexual behaviours.' The child who was causing most concern to the parents and to professionals was referred there in 2023. The issues identified in the referral were in respect of his sexualised behaviours in the home and at school. They completed a preassessment by speaking to the referrer (the targeted early help worker) and the child's mother. Purple Leaf were concerned about the high level of sexualised behaviours he was exhibiting, so recommended that an in-depth assessment and piece of work with the child was required to explore his needs and difficulties, and to consider where the sexualised behaviours may stem from. This required funding from the Local Authority. As the family were effectively 'closed' at the time, as early help had recently withdrawn their involvement, a MARF referral was made to Compass, the front door to CSC, requesting funding. Purple Leaf told the review that they were passed back and forth between CSC and early help and that the funding was not agreed, leaving a need unmet and a risk unknown. Following the Rapid Review meeting there was a piece of work undertaken that recognised the Early Help can be given too much responsibility for children who require a safeguarding response and changes have been made. This means that the issue of funding will clearly be the responsibility of CSC going forward. No recommendation has therefore been made.

24. There were also indicators that the child with extreme sexualised behaviour was being scapegoated in the family both when they lived in the previous Local Authority area and then later in Shopshire. The child was being blamed for his behaviour, and the parents wanted him to be assessed for ADHD due

[5] DPP v Smith 94 established that cutting a significant portion of a woman's hair without consent can constitute actual bodily harm (ABH) under the Offences Against the Person Act 1861
[6] Purple Leaf is a trading name of the West Mercia Rape and Sexual Abuse Support Centre (WMRSASC).

to them believing the problem was innate within him. In 2023 he was prescribed Sertraline, which is used to treat depression, obsessive compulsive disorder, PTSD or anxiety. It appears the child was also scapegoated in other ways, with his bedroom reportedly significantly less furnished/resourced than his sibling's rooms, and the parents saying he was constantly hungry and ate all the food in the house. It is noted that a child can sometimes become the identified problem, which draws attention away from wider issues in the family, which in this case was sexual abuse. This child may be blamed or labelled as difficult, disobedient, or emotionally unstable[7], which was the case here. His behaviour was seen as the problem, rather than as his way of communicating his confusion and distress. Emotional abuse is always part of sexual abuse.

25. There is a need for improved recognition of behaviour as communication, particularly a need to find out what the sexualised behaviour & language may indicate. The behaviors of all the children that indicated they may be exposed to, or victims of, sexual abuse were numerous in this family, when the known or knowable information was considered. It included one of the children presenting as withdrawn and self-harming, another taking an overdose, the youngest saying they wanted to kill themselves, two of the children running away from home having left a note which stated "he rapes us", many allegations of physical abuse (including cigarette burns) from the birth father, allegations of physical abuse from mother's partner, one of the older girls pulling down her pants in school and stating that this is what their father and their older brother do to them, sexual contact and exposing genitals to other children and peers in school and the community, violence between the siblings, and numerous examples of sexualised language. Professionals needed to be confident in speaking to the children and the parents about the children's sexualised language and behaviour to develop a wider understanding of the child's world, as well as a greater understanding regarding sexual boundaries within the home. Practitioners often feel uncomfortable in this area, and they need to need to feel able and confident to ask questions about sex and sexual boundaries with parents when there are concerns raised.

Learning area: the vulnerability of children who are electively home educated.

26. The parents decided to electively home educate their younger children when they had issues about the schools they attended. This was despite hard work by one of the children's schools who did not permanently exclude him, despite his behaviour warranting such a response, due to them recognizing how vulnerable he would be if not in school. This was good practice. At the time of the allegations about Mother's partner in 2023 the younger children had been out of school for around a term. Prior to the decision to electively home educate, there had been concerns about the children's attendance at their primary and secondary schools. The older children had also had periods where they had been electively home educated, following poor attendance, behaviour issues in school, and concerns being shared by the school/s about them.

27. An increasing number of families are choosing to electively home educate their children. This leads to concerns for children where there are already identified safeguarding concerns, including the

[7] Herman, Judith (1992) Trauma and Recovery.

increased isolation of the children and the lack of professional oversight of them when they do not attend school. There are limitations in the statutory responsibility of the Local Authority for electively home-educated children, with no formal duty or power to routinely monitor the quality of home education or the welfare of home-schooled children. This is a national concern and issue that is being considered by the DfE and the national CSPR panel. This is an issue that is considered further in the parallel neglect thematic review being undertaken alongside this CSPR. A recommendation has been made.

28. In the case of the younger children there was a visit from an EHE officer at home within weeks of them being removed from school in 2023, which is good practice. It appeared that the family were organising lessons and learning opportunities for the children, and Mother was reported to be positive about what she had planned. After they came into care in 2023 the children stated that the promised lessons did not happen and that they spent most of their time watching the adults play video games. It is now known that the conditions at home also deteriorated at this time and the police shared information about how the family were living when they visited the home in December 2023, stating that the home was dirty, overcrowded and cluttered.

29. There has been extensive work undertaken in Shropshire in respect of children who are electively home educated. It recognises that those children who are or have recently been open to CSC are most vulnerable, and work will be undertaken with these families to consider and explore motivations, support needs, and potential impacts. This is considered further in the neglect review being published at the same time as this CSPR.

Learning area: recognising when a parent is not being open with professionals

30. Those who knew Mother or worked with her directly found her open and direct with professionals. She came across as plausible and insightful. Having met her as part of the review, the reviewers acknowledge that she is likeable and presents well. Her apparent compliance and engagement was not as meaningful as had been thought at the time. She would share information and agree with professional advice, but this did not make a positive difference to the children, including in respect of the child who was seen to be most concerning by professionals in Shropshire when it came to his sexualised behaviour. From the age of ten years old his school were concerned about his language and his knowledge of sex, including describing sexual acts involving his parents. What is evident is that both parents blamed the child for his behaviour and presented him as the problem that needed to be solved.

31. There was a need to think more critically about the parents' response to the children's behaviour. At the time Mother particularly was seen as responsive, open with agencies, and relatively insightful about the concerns. It is possible that the 'halo effect'[8] was in play. This is where professionals feel reassured when a parent appears to be open, engaged and want the best for their children. There was also a

[8] While this is an Australian document, it is very helpful in assisting practitioners to develop an understanding of how bias influences decision making in child protection in the UK https://cspm.csyw.qld.gov.au/getattachment/dd453153-6025-4cb3-a2d5-e8af32c4df8d/PG-Bias-in-child-protection-decision-making.pdf

view that she had been protective in moving away from an abusive ex-partner. The halo effect can mean that risks are not adequately considered as the parent does not come across as lacking or deceptive. What was not considered was that the mother had been working with agencies in respect of her children for around 16 years and had experience in allaying fears and appearing cooperative.

32. Parents who are experienced in working with agencies can be effective in creating an impression of engagement. Such as attending meetings, returning telephone calls and using jargon which is reassuring to those involved. This perceived compliance needed to be considered alongside the behaviours of her children and the concerns about their ongoing poor emotional and social development. Once it is established that cooperation is not as meaningful as is required, there is a need to ensure that barriers are considered and transparently addressed. In this case the barriers to Mother's engagement included her emotional health following the death of her mother, her own physical health and the impact of the medication she was talking, indicators of a controlling relationship which were evident, and her own adverse childhood experiences, and fear that her children would be taken away. Those involved at the time needed to acknowledge that there were issues with engagement and address why.

33. In this case the parents (it is noted that both were usually seen together) seemed to anticipate and preempt professional concerns by showing off home improvements or making plans for home schooling lessons. However, professionals always need to be sure that this engagement is not superficial and is reflected in their treatment of the children and results in improved outcomes for the child/ren over time. Improving the awareness of safeguarding professionals when parents appear to be cooperative but are not, and requires critical thinking, including awareness of potential bias. This is crucial as this will enable practitioners to recognise when bias may be influencing their judgement. Alongside this, there must be professional curiosity, reflective practice and supervision. There is also a need for multi-agency consideration of concerns alongside considering alternative perspectives, to gather different views and challenge the potential for tunnel vision. There must also be a multi-agency culture of always considering if disguised compliance is an issue in any family. In 2021 a review was completed in Shropshire (Family G) that made the following recommendation, 'The Partnership to consider the best mechanism and criteria for escalating concerns where parents either overtly, or covertly, fail to engage, disengage or demonstrate inconsistent engagement with professionals.' This review has found that there is a need for a review of this approach to ensure it is having an impact. A recommendation has been made.

Learning area: Families that move areas

34. The review has considered the information shared by agencies in the previous Local Authority and can identify many occasions where the potential indicators of on-going sexual abuse in the family home were not robustly identified or addressed. It is acknowledged that much of the work undertaken with the family was over ten years ago, however a recommendation has been made that the safeguarding partners there are informed of the concerns identified, and the need for them to consider the learning

from this case and to cross reference it to current practice to seek assurance that practice has improved.

35. The concerns about sexual abuse were seen as historic rather than potentially current, and the focus of the work when the family arrived in Shropshire was to prevent the recurrence of neglect. There were ongoing concerns indicated about the behaviour of the children, which was thought to be due to what had happened when they were having contact with their father, rather than there being an on-going risk of sexual harm or abuse. The additional needs of the children due to the move, was acknowledged, and it was recognised that the child in need plan should continue, with a new social work assessment being completed in Shropshire.

36. It is known that when children move areas, this can lead to delays in the children receiving support. There can also be slow or insufficient information sharing, which was an issue in this case, with the school and the social worker telling the review that they had to chase information. Moving schools has an impact on children, and for those with additional needs, as was the case here, the move can impact on progress, attendance and wellbeing. A move will lead to changes in professionals and can disrupt trusted relationships for children and parents. One of the children told the review that they had a social worker in the old area who was good, and who would spend time with him and listen to what he had to say. This wasn't something that happened after the move, until the more recent change of worker at the time that the child came into care.

37. It is not clear if a meeting was held to transfer the child in need plan from the previous area to Shropshire. Mother told the review there had not been a meeting. It is good practice to do so, even if it is not required in procedures when children are on a ChiN plan. It was some distance for agencies to travel in the days before virtual meetings were held, so the likelihood of all the agencies attending was low, although this would be expected if the children had been on a child protection plan. It appears that the inability to be sure whether a meeting was held or not is because Shropshire CSC were in the middle of a transfer of records from one IT system to another at the time of the move and has acknowledged that some documents are not available on the new system. This mean that those involved at the time, and since, will not have had all the knowable history available to them.

38. There is also the possibility that parents will use the move to avoid professional scrutiny. Mother told the review that the decision to move was undertaken quickly and that there was not a lot of time to prepare the children or inform agencies. One of the main motivators to move was to ensure no contact with the older children's father, and to gain family support that was available to them in Shropshire. She stated that she had not absconded with the children and that she had fully intended to share her plans with those involved.

Learning area – the child's place in the system

39. Concerns were raised both at the time and during the review about the children's place in the system. They were predominantly allocated to targeted early help, with attempts by other agencies to request a social work assessment largely unsuccessful. Targeted family support workers were allocated to work with the children and family. However, targeted family support workers are not equipped or trained

to address the complexities and risks associated with sexually harmful behaviour within a family. This work requires access to appropriate training, supervision and multi-agency support. At the time that the family moved to Shropshire, the early help system was experiencing high staff turnover and inconsistent management support. Despite the ongoing concerns about the sexualised behaviour of the sibling, the decision to educate the children at home, and concerning behaviours shown by the siblings, including the youngest primary school age child reportedly feeling suicidal, the family remained the responsibility of universal services and/or early help. At no stage was there a strategy meeting held in respect of the sexualised behaviour.

40. Good practice indicates that that if there are concerns about a child exhibiting increasingly sexualised behaviour that is inappropriate for their age, a strategy meeting should be held as it could indicate significant harm. There was no evidence that any Shropshire agency had requested a strategy meeting. While procedures imply that it is CSC who decide whether to hold a strategy meeting and who convene the meeting, other agencies can request that one is held and can challenge a decision not to hold one. There were several times during the work with this family where the review has found that a strategy meeting was required, and some where child protection planning would have been appropriate due to the seriousness of the concerns about the family.

41. There was good practice in 2020 when a member of the extended family came to stay with the family, and it identified that they were potentially a sexual risk to children. A child protection investigation was completed, and the family member was told to leave the home. This episode then needed to be seen as part of a larger pattern where the safety of the children was not prioritised by their mother.

Conclusion and recommendations

42. The consideration of practice with the children and their parents and systems in Shropshire has highlighted several areas of learning. This includes the expectations of targeted early help in the complex area of sexual harm and abuse, and the need to challenge other agencies, along with the recognition of behaviour as communication - particularly what sexualised behaviour & language may indicate about what is happening behind closed doors.

43. Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. They include improving how professionals recognise and support young carers, avoiding isolated thinking, and encouraging professional curiosity.

44. The parallel thematic neglect CSPR has made recommendations in the following areas: The need to improve COMPASS referrals by the inclusion of multi-agency information and concerns, over time, that focus on the impact on the children: Improve the response, across agencies, to concerning information shared by members of the public. Improved contingency and 'exit' planning and clear instructions about what should happen when a child closes to TEH or CSC[9], so that the family and

[9] Any process that is devised should be flexible for use by professionals when a single agency piece of work is concluding.

agencies with continued involvement with a child are clear about expectations: social work assessments to include robust consideration of the information held in Early Help records.

45. Having considered the learning highlighted in this report, the following additional recommendations are made with the aim of ensuring that the required improvement actions are achieved:

Recommendation 1

This CSPR to be shared with the previous Local Authority where Family 1 lived to enable them to reflect on the learning for them, including the need to share all available information about a child/ren to all relevant agencies in a new area when they move and there are known vulnerabilities.

Recommendation 2

The Partnership to consider how it can highlight and improve consideration of the additional vulnerability of children who have moved.

Recommendation 3

The Partnership to consider the report 'understanding and responding to sibling sexual harm and abuse' by Dr Elly Hanson and plan for improved practice. This should include the need for a strategy meeting to be held when a child is showing concerning sexualised behaviour.

Recommendation 4

The Partnership to request an update from the relevant agencies on the work undertaken following the Family G review in respect of escalating concerns where parents are not meaningfully engaged with services. To include how staff are supported and trained about this issue.