Extended Child Practice Review Report

Strictly Private & Confidential

CYSUR 4/2019

Date report presented to the Board:

12th July 2022

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Extended Child Practice Review Re:

CYSUR 4 2019

Brief outline of circumstances resulting in the review

Legal Context

An Extended Child Practice Review was commissioned by CYSUR: the Mid & West Wales Safeguarding Children Board in accordance with statutory legislation set out in section 139 of the *Social Services and Wellbeing (Wales) Act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Volume 2 – Child Practice Reviews*[2] (Welsh Government, 2016).

The criteria for this review are met under Chapter 6, *Extended Child Practice Reviews*:

A Board must undertake an Extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- Died; or
- Sustained potentially life-threatening injury; or
- Sustained serious and permanent impairment of health or development; **and**

the child was either on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding –

- The date of the event referred to above; or
- The date on which a Local Authority (LA) or relevant partner[3] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for child practice reviews are laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[4].

The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and a family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and child protection practice. It should include the circumstances which led to the review, including highlighting effective practice and consideration

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)
[3] Local Authority or relevant partner means a person or body refeed to in S.28 of the *Children Act 2004* or body mentioned in s.175 of the *Education Act 2002*.
[4] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015
5. Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)

of what needs to be done differently to improve future practice. (*Working Together to Safeguard People – Volume 2 – Child Practice Reviews* (Welsh Government, 2016[5]).

The Terms of Reference for this Extended Child Practice Review are at **Appendix 1.**

Timeline

The agreed timeline for the review is 5th December 2016 to 18th June 2018.

The timeline for this review extends beyond the recommended 12-month period prior to the critical event or incident. This is due to the longstanding historic and complex nature of the circumstances within this case. It involves events that have occurred over many years, prior to the referral that alerted agencies in Mid and West Wales to serious concerns in March 2018. Consideration of the historical contextual information is essential if sense is to be made of the children's lived experiences and what led to the intergenerational sexual abuse.

The delay in starting and completing this review has been due to awaiting the outcomes of the parallel complex criminal and care proceedings, which have enabled the Board to be better informed of the very complex nature of the harm suffered by the children.

The timelines, chronologies and analysis submitted by all agencies were discussed in detail during the panel meetings and learning events and have informed the learning included in the report.

Circumstances resulting in the review

This review is centred on the children and grandchildren of Adult Y. It involves intra-familial sexual abuse (incest) of two generations of children and adults. The case came to light in 2018, when one of Adult Y's daughters, Adult D aged thirty, made an allegation to the police that she had been sexually abused by her father on an ongoing basis from the age of fourteen years until she eventually left home. At that time, it was suspected that another of Adult Y's daughters, Adult A, may also have been a victim of sexual abuse by Adult Y.

In 2018, it was decided that the Local Authority (LA) would make an application for Care Orders in respect of Adult A's children, due to the concerns that she may also have been a victim of abuse by Adult Y. On the same day, Police contacted the department to discuss evidence gathered from mobile phones, which highlighted that Adult Y was in a sexual relationship with his daughter Adult A and he was also trying to get Adult B, his granddaughter, pregnant. On 18th June 2018, Adult A and Adult Y were arrested, Section 46 (Children Act. 1989) Police powers[6] were executed on the children, and subsequently, all of Adult A's children were brought into foster care. In the following week, the LA applied to the court for Care Orders, and the children have remained in care to the present day. The care plans for some of the children are long term care and for the younger child, adoption. None of the children have disclosed allegations of sexual abuse.

After repeatedly denying any allegations of abuse by Adult Y, Adult A and her daughter Adult B, disclosed that they had been sexually abused almost daily since their early teens by Adult Y. Adult Y continued to deny any sexual abuse of his daughters and granddaughter. DNA tests were undertaken on Adult A's children and Adult Y as part of the Police investigations and Care

[6] Section 46 of the Children Act 1989 gives the Police the power to remove children or prevent them from being exposed to dangerous environments.

Proceedings; Adult Y was found to be the father of six of Adult A's children, but not the youngest, Child E.

On 18th October 2019, Adult Y was found guilty of repeatedly raping his two daughters, Adult A and Adult D, when they were children, and his granddaughter Adult B. He received a 40-year custodial sentence.

The impact on the children of Adult Y's abuse is significant and is likely to have serious repercussions for their current and future emotional health and well-being. Various assessments of the children following their move into care have confirmed the level of trauma and harm they have experienced and the significant impact on them. They meet the criteria as outlined above, for having sustained "*serious and permanent impairment of their health and development".* It should be noted however, that every effort is being made to offer all the victims (children and adults) as much help and support as possible to enable them to recover from the abuse they have suffered and to come to terms with their complex family relationships. This support is ongoing and will be long term.

Family composition

Ages calculated as of March 2018 when concerns raised.

Adult Y **- Father**: age 62

Adult A **- Mother** (Daughter of Y): - age 37

Children of Y and A

Child A age: 15

Child B age: 11

Child C age: 6

Child D age: 4

Adult B age: 20

Adult C age: 22

Child of Adult A

Child E age: 2

Other significant adults

Adult D – Daughter of Adult Y & Sister of Adult A

Adult E – Partner of Adult Y

Adult F – Father of child E

The current legal status of the children

The children are in the care of the Local Authority with different long term placement arrangements in place. The Initial Child Protection Conference occurred in 2018 and the children were registered under the category of 'at risk of sexual abuse'.

Family involvement in the review

It is expected that as part of the review process, family members will be invited to participate, so they can add insight, knowledge and learning to the process. The Panel initially agreed that it would be helpful and appropriate for Adult Y, Adult A, Adult B, Child A and Child B to be invited to participate. It was felt, following consultation with professionals working directly with the children, that the younger children were not of a sufficient age or understanding to be asked to participate, and that to try to involve them may not be in their best interests, at a time when they are receiving support to come to terms with what has happened to them. Child A and Child B indicated that they did not want to participate. Adult Y did not respond to the opportunity to have an initial discussion with the panel chair to discuss how he may be able to contribute to the review, although it is acknowledged given his reported refusal to acknowledge or accept any responsibility for his actions, it is anticipated any contribution would be of limited value in terms of learning.

The review panel are hugely grateful to Adult A for contributing to the review and for sharing some very difficult experiences and memories during an interview with the lead reviewer and one of the Panel members, who facilitated the interview. Adult B had initially agreed to meet with the lead reviewer but then decided not to participate.

The Panel would like to express the sincere hope that by publishing this review, the suffering experienced by all the members of this family can lead to some positive learning, and that they may find a degree of healing and closure.

Chronology of events

The review panel have considered submissions from agencies in the chronology of events taking place between the 5th December 2016 and the 18th June 2018, as well as relevant contextual information considered important from outside of this period.

The following information that falls outside of the timeline is included for contextual purposes to inform understanding of the nature of the abuse that is the subject of this review. This information has been collated from agency records, as well as information provided by Adult A.

Relevant contextual information

Adult Y has a complex history, with three previous marriages and children from those relationships that he has not maintained contact with. He has served time in prison for a conviction related to burglary and criminal damage. In his teenage years, there was an incident involving an allegation of indecent assault for which he was convicted and given a supervision order for two years.

Following therapeutic support, and a lengthy period of trying to make sense of her early childhood experiences and the extensive grooming by Adult Y over many years, Adult A was able to share recollections of her childhood and relationship with Adult Y. The information is based on Adult A's personal account and perception of her traumatic and abusive history, and has not been triangulated with any official records or submissions.

Adult A recalls that until the age of eleven, she did not know who her biological father was, and lived with her mother and siblings. She describes a very unhappy and neglectful childhood in which she recalls involvement of children's services on more than one occasion. She describes herself as undernourished, small for her age, quiet and reserved. She can recall being bullied at school for her appearance due to wearing clothes inappropriate for her age that were purchased from

charity shops. She felt unwanted and unloved and says she did not have a good relationship with her mother.

Adult A did experience some positive care from one of her mother's partners, but he was violent to her mother and when they separated, her mother could not cope with caring for the children, so she tracked down Adult A's birth father and introduced her to him. At the time, Adult A was aged eleven but says she looked much younger. Adult Y was living with his partner, Adult E at the time. Following visits and outings with her father and Adult E, Adult A moved to live with them on a full-time basis in England when she was aged twelve. Reports received from the Local Authority in England highlight that Adult A became pregnant when she was thirteen years old. Adult A has given birth to nine children, had four miscarriages and had one child who suffered a cot death during the time the family lived in Wales. Adult A describes being happy about the move to live with Adult Y and Adult E as she had found them to be kind, loving and able to offer her better care than her mother did. She enjoyed lots of new experiences with them.

Adult A says Adult Y told her he was not her birth father, even though he was in a relationship with her mother when Adult A was born. Adult A said the grooming and sexual abuse happened very soon after she was introduced to Adult Y. By the time she was twelve, she was having regular sexual intercourse with Adult Y and believed she was in a positive loving relationship with him. She described enjoying the special secret relationship and liked the attention Adult Y gave her. She knew the relationship had to remain a secret due to everyone believing Adult Y was her father. He told her that he would go to prison if anyone found out and that Adult A would lose her children. Adult A said she loved having her babies and would not do anything that would mean losing them.

Adult A continued to live with Adult Y and Adult E and kept the identity of her children's paternity a secret. When professionals questioned her about the father of her babies, she told them either she did not know who the father was, or that it was as a result of a 'one night stand'. Subsequently, all of Adult A's children have lived with Adult Y since birth, and have viewed Adult Y as a significant adult in their lives. There is some confusion regarding whether the children saw Adult Y as their father or grandfather as the boundaries were so blurred within the household.

There is evidence of Adult Y exercising a regime of control over Adult A, which escalated at one point when he introduced a new element into their relationship.

Adult Y started to communicate with Adult A through emails, texts and messages through a spirit adviser/psychic who instructed Adult A to engage in sexual activity both with Adult Y and another individual. Adult A describes being afraid of the spirit adviser/psychic and believed it was a real person telling her what to do and threatening her if she didn't comply. It is proven that the messages were in fact part of a deception carried out by Adult Y, to continue to control and manipulate Adult A and to act on more of his own sexual fantasies.

The family (as described above) moved to South Wales in August 2015. Prior to this, the family lived in another part of Wales, but have mainly lived in the South East of England.

Timeline of events

The family became known to Children Services in South Wales in December 2016, when Adult B presented with emotional difficulties in the home and was threatening to self-harm with a knife. Police were called and they forwarded a referral to Children Services. It was noted she was under the Child and Adolescent Mental Health Services (CAMHS) at the time.

An anonymous referral was received from the NSPCC in January 2017, alleging that Adult A was in a relationship with her father Adult Y, and that all her children were the result of the incestuous relationship. A joint Section 47 investigation (Children Act 1989) was undertaken by Children's Services and the Police, which included extensive enquiries with the older children and adults within the family. There were several strategy meetings held during 2017, which included all professionals involved with the family. Adult A denied the allegation that she was in a relationship with her father and that the children were born as a result of any relationship with him. At the time, Adult A refused DNA tests on her children. The enquiries lasted for twelve months. At a final strategy meeting, dated 25/10/17, it was concluded that the evidence gathered up to that point could not support the concerns raised and, in accordance with legal advice, did not reach the threshold that would enable professionals to instigate legal proceedings and thereby pursue DNA testing as part of the process. The School Safeguarding and Attendance team remained involved after this point and conducted home visits and a school review meeting.

A few months later, in March 2018, one of Adult Y's daughters, Adult D, made an allegation to the Police that she had been sexually abused by her father. Both she, and subsequently Adult A and Adult B, disclosed that they had been sexually abused on almost a daily basis since their early teens by Adult Y. Adult Y continued to deny any sexual abuse of his daughters and granddaughter. DNA tests were undertaken upon Adult A's children where it was suspected that Adult Y was the father, as part of the Police investigations and Care Proceedings. Adult Y was found to be the father of all of Adult A's children, apart from the youngest child.

As part of the Police investigation and criminal proceedings, it was considered that Adult Y had groomed his daughters and granddaughter by acting as a spirit adviser/psychic and directing what they should be doing. Adult Y was the author of a series of communications to Adult A, presenting them as coming from a spirit adviser/psychic. He used these messages to continue his control and abuse of Adult A, using the spirit adviser/psychic to instruct Adult A to engage in activities that he was in fact orchestrating and controlling. Adult Y was found guilty of repeatedly raping his two daughters when they were children and his granddaughter Adult B and received a substantial custodial sentence. Adult Y's sexual abuse of his two daughters as children occurred in two Authorities in England prior to their move to Wales.

Within the Care Proceedings, which commenced in 2018 and concluded in 2019, psychological assessments were undertaken with four of the children by a specialist children's hospital. The psychological assessment reports completed in April 2019 highlighted that all of the children had suffered significant harm, which included:

- Post-Traumatic Stress Disorder (PTSD)
- Exposure to emotional harm and neglect
- Selective mutism
- Signs of avoidance, low mood and separation anxiety
- Increased risk of sexual exploitation
- Poor sexual boundaries
- Confusing information regarding parentage
- Symptomatology related to sexual abuse

Family dynamics and relationships

It is important that we consider the historical nature of the abuse as it helps to inform our understanding of the actions of Adult A in concealing her own abuse and the identity of her children's paternity.

If we look at Adult A's history, we can see she was a child who suffered from abuse and neglect in her early years and was vulnerable when she first met Adult Y. She was an unfortunate victim of Adult Y's predatory grooming and abusive intentions at a time when she was still a young and vulnerable child. Adult Y was in a position of trust and abused that position in an opportunistic way almost as soon as he was introduced to his daughter. Once ingrained in a sexually abusive scenario with Adult Y that resulted early in the birth of her children, Adult A believed she had too much to lose if she disclosed the true nature of the relationship. She also believed the relationship to be a positive one for her and her children and described herself as 'being in love' with Adult Y and seeing him as her boyfriend. Adult A felt jealous of Adult E's relationship with Adult Y. Adult A said she was unable to think of anything that might have alerted people to the abuse; possibly if she didn't think she would lose her children, she might have told someone.

In considering the family dynamics and the role of Adult Y's partner Adult E in the household, it appears that Adult E became less visible. Adult A describes Adult E as going from being a successful career woman to someone under Adult Y's control, who became alcohol dependent and someone who would get intoxicated and go to bed early, leaving her and Adult Y together. Adult E has denied any knowledge of the relationship between Adult Y and Adult A, and Adult A states she was devastated to learn that Adult Y had continued to have sexual relationships with Adult E, as she thought he was faithful to her.

Adult A has been receiving help and support, including therapeutic input for two years. She states that this has helped her to understand how vulnerable she was when she was introduced to Adult Y. Her view of Adult Y now is that she 'hates him' for what he has done to her and her daughter. Adult A shared that it was when she discovered that Adult Y had abused Adult B that she finally felt able to disclose her own abuse. She had always thought that her relationship with Adult Y was unique and special, so was devastated when she discovered that Adult Y had also been abusing Adult B.

The abuse of Adult B is not explored within this review as it sits outside the terms of reference. However, it is worth noting that this was another aspect of the controlling and abusive nature of Adult Y's relationship with his own children and grandchild that sadly remained undetected for a long time. Due to Adult B not wishing to contribute to the review, it is not possible to explore from her perspective how this abuse may have been exposed, or what, if anything, any professionals may have been able to do to identify the abuse earlier.

When we consider research about intra-familial sexual abuse, we can better understand the dynamics in such relationships, how complex they are and why it was so difficult for Adult A to recognise the abusive nature of her relationship with Adult Y. In her own words, she did not see herself as a victim and was heavily committed to maintaining the relationship and keeping it a secret. Adult Y introduced a spirit adviser/psychic dynamic into the relationship, and this further complicated the coercive and controlling nature of Adult Y's hold over Adult A and she felt unable to do anything about it so continued to focus on being a good mother to her children.

Learning

The identification of the practice and organisational learning has been drawn from the following key elements of the review:

- The production of a merged multi-agency timeline and agency analysis
- Learning events for professionals
- Interview with Adult A
- Discussions within the review panel meetings
- Case record review (legal bundle)
- Independent Reviewers and Chair's analysis
- Literature Review
- Consideration of two published Serious Case Reviews with issues of intra-familial abuse

The panel agreed that there would be merit in seeking professional advice and consultancy from someone with expertise in the field of intra-familial abuse. Dr Sue Roberts from Swansea University has provided some reflective practice insight into the issues in this case, and offered advice on appropriate research materials for the reviewers to refer to. These were referenced in the learning event and at the review panel discussions.

The learning events

A learning event was held in October 2021, and was well attended by senior managers of all the relevant agencies who were involved with the family.

The following agencies were represented at the learning event;

- Health Board
- Local Authority Children's Services (Social Services and Education)
- Dyfed-Powys Police
- Local Authority Adults' Services (Adult Safeguarding)

Each of these agencies had held an in-house learning event to prepare their presentations and questions prior to the main learning event. The learning events were structured this way to widen out the practitioner group that could contribute to the learning.

The learning event was facilitated by the Lead Reviewer and Second Reviewer, supported by the Review Panel Chair. As described above, the learning event considered the timeline of contacts and events for the period December 2016 to June 2018. The following themes were explored based on the outcome of research and issues arising from consideration of events that took place within the family.

- Adult A's vulnerability as a child
- Childhood experiences (domestic abuse, emotional abuse and neglect, potential attachment issues with birth mum)

- No involvement with birth father until aged twelve – impact of absent father
- Intra-familial abuse/incest – strong denials throughout pregnancies and investigations
- Coercion and controlling relationships (the use of a spirit adviser/psychic to control the victims)
- The impact of repeated pregnancies from the age of thirteen
- The impact of the substantial historical factors in the life of this family e.g. Adult Y's previous offending

Children's voices;

- What may have been happening for Adult A at the time the abusive relationship started and thereafter
- What impact has the abuse had for Adult A's children, have their voices been considered throughout

Professionals were asked to consider the following questions (these responses are compiled in the following section):

- What went well in your agency; what have you identified as the areas of good practice?
- What do you feel did not go well in your agency?
- What do you do differently now in terms of practice/procedure, and what are your agency's biggest learning points?
- What are the actions you feel your agency needs to take to ensure any learning changes what you do in the future?

Practice and Organisational Learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances.

Practice and organisational learning

In considering the historical context in this review and particularly Adult Y and his background, it is possible that his offending behaviour may have started prior to his abuse of Adult A. There is however, no presenting evidence to confirm this, other than the information about the incident that took place in his childhood. There is much that could be learnt about Adult Y, his previous relationships and his behaviours and motivation to offend, but this sits outside the remit and timeline of this review and relates to historical practice outside of the current local authority, therefore we have not endeavoured to pursue this line of enquiry. We have however captured some of the learning from research on intra-familial sexual abuse, and have also considered some interesting research on Trauma Bonding and Stockholm Syndrome given the strong attachment shown by Adult A to Adult Y as her abuser.

A key factor in preventing the ongoing abusive relationship between Adult Y and Adult A that persisted for many years lies in the unknown identity of the father of Adult A's children throughout the many pregnancies she had, including those that occurred before she was sixteen and under

the 'age of consent'. Had there been investigations using DNA to test the paternity of Adult A's first children, then the abusive relationship may have been detected earlier. It is not clear whether the local authority they were living in at the time considered this as a possibility and/or whether they concluded they did not have sufficient concern or grounds to do so. Equally had Adult A had confidence in any of the professionals she met at the point she was still a child, before the grooming process had become well established and had felt able to disclose her relationship with Adult Y, help may have been available sooner. This is all knowledge that comes with hindsight and is beyond the remit of the review.

It is worthy to note, as it may help us to consider in the future, that if we were presented with similar circumstances, that we may need to think about whether the young person could be a victim of abuse and specifically intra-familial abuse, and how we can take protective action when the young person is not willing or able to disclose the abuse. We acknowledge that our current knowledge and understanding of grooming and sexual exploitation provides professionals with better insight than was likely to be the case twenty-five years ago, and the discussions in the learning events have confirmed this. It is hoped that this review may provide some useful insight and learning from considering the historical context as well as the events contained within the timeline.

In conducting this review within the parameters of the guidance and agreed timeline, the focus of our learning takes place from the point at which Adult A's abuse becomes known to agencies in South Wales. It is pleasing to note that there is much evidence of good practice from several agencies in responding to the referral and positive examples of persistence from individuals in continuing to exercise professional curiosity in relation to this family.

Relevant learning from exploration of the themes and from previous reviews

Previous reviews

The panel also considered the executive summaries from two English Serious Case Reviews (SCRs)[7]. These SCRs undertaken in Swindon in 2004 and Sheffield in 2009 detail similar case histories to this CPR. Both feature intra-familial sexual abuse with multiple children being fathered by their grandfather over a long period of time, as well as multiple pregnancies that did not reach full term. Both SCRs describe coercive and controlling behaviour; in the Swindon SCR, this is described towards the professionals and in the Sheffield SCR towards the victims. The learning within these SCRs is predominantly related to process, procedure and training.

There are some parallels between the Sheffield SCR and this CPR in relation to professional knowledge of, and confidence in, the use of DNA testing in cases of incest and sexual abuse. The current review reflects those previous reviews in finding professionals frustrated with the legalities surrounding the DNA screening process. It is felt that earlier screening would have provided the clarity required, however Adult A refused to agree to screening and therefore the paternity of the children remained unknown during the initial enquiries. Changes to the law surrounding dispensing with consent for what would be a physical intervention (an assault in the eyes of the law) is a contentious one.

[7] SWINDON AREA CHILD PROTECTION COMMITTEE SERIOUS CASE REVIEW 'B' FAMILY, EXECUTIVE SUMMARY September 2004, Sylvia Duncan Consultant Clinical Psychologist

Sheffield Safeguarding Children Board in association with Lincolnshire Safeguarding Children Board Serious case review, Executive Summary, In respect of: Q Family, Professor Pat Cantrill, August 2009

Intra-familial child sexual abuse

The National Action Plan on 'Preventing and Responding to Child Sexual Abuse Working Together to Safeguard People 2018'[8] issued by the Welsh Government provides helpful information regarding the sexual abuse of children and how to prevent and respond to it.

The Centre for Expertise on Child Sexual Abuse (CSA) has published key messages from research on intra-familial child sexual abuse[9] which is referenced below.

Practitioners who come into contact with children and their families should seek to routinely share information with parent/carers about available resources and the need to be aware of the ways in which they can help to keep the children in their care safe from CSA. This should include an understanding of the impact that non-contact online CSA can have on children. Practitioner learning can be supported in several ways; through the dissemination of information and resources, through online learning and through direct awareness raising and training. Good practice can be promoted through the inclusion of safeguarding as a standing item at team meetings and through supervision. This can assist agencies to identify practitioner learning needs.

In 2018, the Welsh Government funded Stop it Now! Wales[10] to develop and deliver a campaign aimed at tackling child sexual abuse by enabling the public to play a more active part in preventing the sexual abuse of children. The 'Child Sexual Abuse - What we all need to know' campaign[11] communicated key advice and information to the public through awareness raising involving traditional media, social media, and resources. Simultaneously, learning sessions for parents/carers and practitioners who work with children and families were delivered across each of the six Regional Safeguarding Children Board regions. The Mid and West Wales Safeguarding Board has extensively promoted all of these events and resources with practitioners, carers and parents as part of its work implementing The National Action Plan on Preventing and Responding to Child Sexual Abuse.[12]

Research[13] has identified four likely impacts of CSA:

- Traumatic sexualisation (where sexuality, sexual feelings and attitudes develop inappropriately)
- A sense of betrayal (because of harm caused by someone the child vitally depended upon)
- A sense of powerlessness (because the child's will is constantly contravened).
- Stigmatisation (where shame or guilt are reinforced and become part of the child's self-image).

To these can be added secrecy (including the fear and isolation this creates) and confusion (because the child is involved in behaviour that feels wrong but has been instigated by trusted adults). While these impacts are not unique to intra-familial CSA, their combination and intensity in this context makes the experience particularly damaging. As part of the learning, professionals

[8] National Action Plan on 'Preventing and Responding to Child Sexual Abuse - Working Together to Safeguard People 2018

[9] Key messages from research on intra-familial child sexual abuse Di McNeish and Sara Scott DMSS Research June 2018

[10] Stop it Now! Wales

[11] Stop it Now! Wales – What we all need to know

[12] National Action Plan Preventing and Responding to Child Sexual Abuse, Welsh Government (2019)

[13] Key messages from research on intra-familial child sexual abuse Di McNeish and Sara Scott DMSS Research, June 2018

have had to consider the dilemma of working with Adult A as a child victim, but also as an adult with children, continuing to live with her abuser and putting her children at risk from him. This is not straightforward and dealing with all the complexities and dynamics in this case, has tested professionals who have remained focused on protection and keeping the welfare and best interests of the children at the core of their work, whilst working sensitively with Adult A.

Although children find it very difficult to tell us about the harm they are experiencing, they may show other emotional, behavioural and physical signs of their abuse. It is vital that professionals have the knowledge, skills and confidence to recognise when children might be showing them that something is wrong, as well as the potential indicators of sexually abusive behaviour in those who may be abusing them. In addition, there are some factors within the family or environment which can increase opportunities for abuse to occur, and understanding what these are will enable us to reduce risks and build strengths when we are concerned. The CSA Centre's new Signs and Indicators Template[14] helps professionals to gather the wider signs and indicators of sexual abuse and build a picture of their concerns.

"It is essential that children's disclosure is not used as the threshold for action with regard to safeguarding. Many children never disclose, while others may disclose partially or retract allegations of abuse. This clearly indicates that much work is needed to support children's disclosures – but, rather than placing responsibility on the child to disclose, the emphasis should be firmly on increasing understanding of CSA and the disclosure process and providing a 'safe' place which can enable telling".[15]

Intra-familial child sexual abuse refers to child sexual abuse that occurs within a family environment. Perpetrators may or may not be related to the child. The key consideration is whether the abuser feels like family from the child's point of view**.** It is interesting to note that Adult A tells us that Adult Y convinced her that he was not her biological father even though his name was on her birth certificate. This may have made a difference to her perception of the relationship as not being abusive, particularly as she said she welcomed the special attention she received and saw herself as a willing participant. The grooming and abuse first occurred when Adult A was a child and as such, she was unable to give informed consent.

CSA in the family is rarely an isolated occurrence and may go on for many years as in the case of Adult A. Much of this abuse in the family remains hidden. Children may fear their abuser, not want their abuser to get into trouble, feel that the abuse was 'their fault', and feel responsible for what will happen to their family if they tell. [16] Adult A shared that she loved having her babies and caring for them and therefore disclosing her relationship with Adult Y when she became an adult was not an option as she was frightened of losing her children.

Disclosure

Disclosure is a complex, individual and often painful process. It is not a singular event – although it is often presented as such – and it is often delayed.[17] It is crucial that such complexity is acknowledged and understood. Indeed, a "pressure cooker effect" can be experienced by children who may want to tell about their abuse but at the same time do not want others to know.[18] A

[14] CSA Centre: Signs and Indicators Template
[15] Chouliara et al, 2011
[16]Responding to child sexual abuse: Learning from Children's Services in Wales Centre for Expertise in Child Sexual Abuse Sue Roberts September 2020
[17] Durham, 2003
[18] McElvaney, Greene, and Hogan (2012)

number of personal, interpersonal, and sociocultural factors inhibit disclosure of child sexual abuse.[19] These include: the power and authority of the perpetrator, together with victim/survivor dependence on him/her; a family unit characterised by violence and limited communication channels; and social isolation.[20] Other barriers to disclosure identified in the research literature include: fear of the consequences following disclosure; concerns about others' reactions, in particular, not being believed; concern for others' safety; feelings for the abuser[21]; and a lack of opportunity to tell of the abuse[22]. Yet others point to barriers including victims not having the words to describe the abuse; blaming themselves for the abuse; or viewing it as "normal".[23]

In this case, it appears that Adult A's belief that she was in a relationship with her abuser, together with fears that she might lose her children, proved powerful influences in maintaining the abuse and ensuring her silence. The "absence of a capable guardian"[24] within the household may also have facilitated the abuse and inhibited disclosure.

Many child victims do not recognise that they are being abused until much later, often when they are adults. We can see that this was very much the case for Adult A.

Trauma Bonding

In a publication by PACE (Parents against Child Exploitation)[25], they describe the impact of Trauma Bonding and suggest it may also be known as Stockholm Syndrome. They describe it as "*a deep bond which forms between a victim and their abuser*".

They suggest that victims of abuse often develop a strong sense of loyalty towards their abuser, despite the fact that the bond is damaging to them.

They describe the following conditions as necessary for trauma bonding to occur:

- To be threatened with, and to believe, that there is real danger
- Harsh treatment interspersed with very small kindnesses
- Isolation from other people's perspectives
- A belief that there is no escape

The symptoms of trauma bonding can manifest:

- Negative feelings for potential rescuers
- Support of abusers reasons and behaviours
- Inability to engage in behaviours that will assist release/detachment from abusers

In her interview with the Reviewer, Adult A is clear that she did not identify herself as a victim of child sexual abuse when the relationship with Adult Y started. She described their relationship as one where Adult Y was her boyfriend, and she enjoyed the secrecy of it. An article by Julich

[19] Tener & Murphy, 2015
[20] Schonbucher, Maier, Mohler-Kuo, Schnyder, & Landolt, 2012; Sivagurunathan, Orchard, MacDermid, & Evans, 2019; Tener, 2018
[21] Morrison, Bruce, & Wilson, 2018
[22] Jensen et al., 2005
[23] Anderson, 2006, p413
[24] Clayton et al. 2018
[25] PACE UK

(2018)[26] makes a connection between Stockholm Syndrome and child sexual abuse. The article, based on an analysis of unstructured interviews, identifies that the emotional bond between survivors of child sexual abuse and the people who perpetrated the abuse against them is similar to that of the powerful bi-directional relationship central to Stockholm Syndrome as described by Graham (1994).

Professionals have expanded the definition of Stockholm Syndrome to include any relationship in which victims of abuse develop a strong, loyal attachment to the perpetrators of abuse. Some of the populations affected with this condition include concentration camp prisoners, prisoners of war, abused children, and incest survivors, victims of domestic violence, cult members, and people in toxic work or church environments.

Stockholm Syndrome is often found in toxic relationships where a power differential exists, such as between a parent and child or spiritual leader and congregant. Aspects of Stockholm Syndrome could be identified in the responses of adult survivors of child sexual abuse, which appeared to impact on their ability to criminally report offenders. An emotional bond, which has enabled the sexual abuse of children, has served to protect the offender long after the abuse has ceased. The implications of Stockholm Syndrome could offer valuable insights to those working in the field of child sexual abuse.

We can see aspects of trauma bonding between Adult A and Adult Y. From her recollections of what happened to her as a child, she did not perceive there to be physical threats present in the relationship or a sense of fear and violence involved but what she was clear about was the need to keep the relationship a 'secret' – her fear was to lose her children. It is likely that Adult Y was very much aware of this and did in fact use this to psychologically control Adult A both as a child and as an adult parent.

We are grateful for the professional advice and support of Dr Sue Roberts, Swansea University who signposted the learning to consider research on intra-familial child sexual abuse, as identified below:

"Considerations of dissociation, betrayal trauma, and complex trauma in the treatment of incest", David M. Lawson & Sinem Akay-Sullivan

In this research review, the focus is very much on the dissociation of survivors of child abuse, especially when the perpetrators are from within the child's caregiver system, and how this can be accounted for by the concept of betrayal trauma. The research suggests that, with few exceptions, little appears in the literature integrating dissociation, betrayal trauma, complex trauma, and incest for the purpose of treatment. The purpose of this review is to examine the relationship between trauma-related dissociation, betrayal trauma, and complex trauma, and how understanding these concepts and their relationship can inform the treatment of incest. This may provide useful insight for those practitioners who are tasked with supporting survivors of incest.

"The secret of intra-familial child sexual abuse: who keeps it and how?", Dafna Ten

This article analyses how women survivors of intra-familial child sexual abuse perceive the family members who took part in keeping it secret and their tactics for doing so. Analysis of twenty in-depth interviews with Jewish Israeli women revealed unique ways of guarding the secret. These were attributed to the perpetrator, the mother and the family. Secret-keeping tactics included

[26] Stockholm Syndrome and Child Sexual Abuse, Shirley Julich (2018)

presenting a normative public identity or an unstable psychological identity, presenting multiple personas, reframing the abuse, concealing any trace of the secret after it was disclosed, as if the abuse had never happened, and making a monument of the abuser. These tactics are discussed in the context of silencing, the interpersonal relations orientation model, and the wider concepts of secrecy in society. Implications for professional practice and for society are considered, and new attitudes toward intra-familial child sexual abuse secrecy are suggested.

This article may provide some insight for practitioners working with adult survivors of intra-familial abuse such as Adult A. Her experience over many years in maintaining and guarding the 'secret' needs to be explored using a range of concepts in order to fully understand the complexity of the relationship between her perpetrator, his other victims, including how other family members experienced and understood the relationships. Whilst not all of the article relates specifically to this case, there is some interesting learning for practitioners in the field of intra-familial sexual abuse.

Perpetrators and explaining offending

Those who perpetrate intra-familial abuse have easy access to victims and opportunities to offend, often as a result of their role as caregivers within the family unit. On environmental factors, such abuse "generally takes place in a familial climate of pervasive fear and terror, in which ordinary caretaking relationships are disrupted".[27] As is the case with sexual offenders who offend against adults, child sexual abusers appear to be a heterogeneous group who share some characteristics including: "poor social skills, low self-esteem, feelings of inadequacy, a sense of worthlessness and vulnerability". In addition, they may have difficulties with adult relationships, and present with "feelings of inadequacy, humiliation and loneliness".[28] This is often attributed to negative early attachments to parents and caregivers – as a result, they may be fearful of, and find it hard to form, trusting relationships.[29]

Research suggests that some male perpetrators of CSA are likely to have experienced some form of maltreatment and/or sexual abuse in childhood, and/or dysfunctional family backgrounds. This may result in "maladaptive perceptions of the world".[30] Cognitive distortions may also feature, underpinning offending behaviour[31] and enabling minimisation and justification of abuse.

On explaining sexual offending against children, Sullivan & Sheehan[32] note that a sexual interest in children may be a common but not the sole motivation for abuse. Rather, other factors may feature, including gaining "personal affirmation" and a desire for power and control. A sense of entitlement and of children as sexual beings is often evident in the narratives of intra-familial abusers, particularly fathers who abuse their own children.[33] In their work on child molesters' implicit theories, Ward and Keenan[34] refer to entitlement as being characterised by a perception that children exist to serve the perpetrators' sexual needs as the head of the household. This may be relevant in this case.

[27] Anderson (2006, p410)
[28] Robertiello & Terry, 2007, p.512
[29] Horvath et al. 2014
[30] Sullivan & Sheehan, 2016, p77
[31] Horvath et al. 2014
[32] Sullivan & Sheehan (2016, p76)
[33] Roberts, 2017
[34] Ward and Keenan (1999)

Learning identified by individual agencies

Children's Services

Identified Good Practice

- There is evidence of children's services staff demonstrating professional curiosity, constantly reviewing and checking the information they had to try and make sense of the complex 'history' of this family.
- Children's services gathered information from other Local Authorities and wider family members to inform their understanding of a very complex network of individuals living together with Adult A and Adult Y.
- There is evidence of child centred practice and planning across children's services in collaboration with health practitioners in trying to respond to the individual needs of all the children involved in this case.
- There is evidence of timely discussions between the adult safeguarding team and children's services social workers.
- Children's services managers have recognised the need to support staff in working with complex and traumatic cases. They have developed a pod system[35] to do this.

Family's Perspective

- Adult A was reluctant to engage fully with agencies initially due to the fear of losing her children and maintained for a long time the position that Adult Y was not the father of her children.
- Adult A acknowledges that she would only have felt able to confide in and disclose the abuse from Adult Y to someone in a position of trust if she had confidence in the professionals, and an assurance that she would not lose her children. Staff were not in a position during the investigation and subsequent enquiries to give such an assurance.

Learning

- Children's services to continue to reinforce the need to ensure staff are well trained on both the indicators and best practice multi-agency response to sexual abuse and exploitation, and continue to support and promote strong and robust multi-agency working to achieve good outcomes for children.
- Further work is needed to support practitioners to work with confidence, particularly in 'grey' areas of professional uncertainty where concerns exist, sometimes long-standing, but where the threshold for statutory intervention is not met. This work should support practitioners to explore and develop creative ways to develop trusting longer term relationships with resistant families who are unwilling to engage with services.

[35] A systemic practice model of social work intervention where practitioners from different disciplines work together collectively to provide a service and respond as a unit, as opposed to case responsibility being carried by one named individual key worker.

Education

Identified Good Practice

- There is evidence of professional curiosity and staff constantly reviewing and checking the information they had to try and make sense of the 'history' of the case.
- Staff in education services proactively raised concerns about the family and made links with the attendance service to offer support, acting appropriately within the remit open to them based on the presenting circumstances.

Family's Perspective

- Adult A acknowledges that she maintained the identity of her children and true nature of her relationship with Adult Y as a tightly guarded secret.
- Adult A believes she did all she could to ensure her children were cared for and educated appropriately.

Learning

- Education have recognised the need to make improvements to their recording systems that did not always demonstrate good practice, and have introduced electronic recording for safeguarding in schools
- Training on child sexual abuse has been rolled out to staff in schools.
- The review highlighted the importance of the role of the School Safeguarding and Attendance Team who played an important role in monitoring and supporting the family outside of formal statutory intervention in safeguarding

Police

Identified Good Practice

- Staff constantly reviewed and checked the information they had to try and make sense of the 'history' of the case.
- Police worked collaboratively with partners and colleagues in other areas to gather information as Adult Y and Adult A had lived out of the area previously.
- Referrals that were made to the Police were investigated without delay, and prompt arrests were pursued when sufficient information to act was available.

Family's Perspective

- Adult A acknowledges that she lied to the Police in order to maintain her secret relationship with Adult Y, and was aware without DNA evidence, it was difficult for them to prove or substantiate the allegations and concerns.

Learning

- Children's services identified a delay in the communication of relevant historical information from the Police, between the strategy meetings and the child protection conference. This information was received at a later stage as the Police had to apply for a micro phish record and await its arrival between the two meetings. If such information is likely to be sought, it is recognised this should be noted and acknowledged at the initial strategy meeting.
- The Police acknowledged a delay in pursuing DNA testing. Legal challenges and professional frustration associated with obtaining consent and its link to establishing paternity raised some interesting dilemmas for all professionals and agencies.
- As a result, the learning from this case has already been developed for use as in-house police training, and the Police are aware of the need to use their own accredited DNA systems.
- The Police recognised that the 'early arrest' following notification of disclosure enabled the safeguarding of children, and that the early advice from the CPS supported this swift action.

Health

Identified Good Practice

- There is evidence of health staff exercising professional curiosity with regard to this family.
- Services constantly reviewed and checked the information they had to try and make sense of the 'history' of the case.
- Health professionals worked with colleagues in other areas to gather information as Adult Y and Adult A had lived out of the area previously.
- It can be seen from the records that the Health Visitor went above and beyond to safeguard this family and was very persistent in maintaining an interest and oversight of the family.
- There is evidence of child centred practice and planning across children's services and health in trying to respond to the individual needs of all of the children in this family.
- Health workers made multiple attempts and used various methods to try and engage with the family in a creative and persistent manner. Often they were having to act on an instinct that things were not right within the family relationships, but had no clear evidence to take protective action. They worked hard to keep avenues open for continued engagement with the family.
- The GP surgery now hold regular meetings to share information between professionals who may have concerns about a family. They also are able to use their computer systems to flag concerns and share information.

Family's Perspective

- Adult A has acknowledged the journey she has been on since disclosure, and the help she has received has helped her better understand her victim status. She felt unable to share anything that might have helped agencies to discover what was happening sooner.

Learning

- The Health Board, as a key partner agency of the Mid and West Wales Safeguarding Board, have played a pivotal role in promoting actions associated with the National Action Plan on Preventing and Responding to Child Sexual Abuse, and will continue to provide CSA training and promote the 'Stop it Now! Campaign', materials and training.
- The learning from this case will be shared in internal safeguarding training.
- The GP surgery has introduced counselling services into its practice premises, which can reduce delays in referrals and promotes accessibility to service users who may have been victims of sexual abuse.
- The GP surgery conducts regular multi-disciplinary meetings, and has introduced a flagging mechanism to alert all staff of any safeguarding concerns. Consideration should be given for this model of care being introduced in all primary care surgeries.
- Since the events of the timeline took place, the Health Board has introduced an electronic mechanism for the sharing of safeguarding information in pregnancy, which involves the timely sharing of information between Midwifery, GP and Health Visiting Services.

Adults' Services

Identified Good Practice

- There is evidence of timely discussions between the adult safeguarding team and children's services workers.
- Adult A has received good support as an adult victim of abuse from relevant third sector organisations as part of the family court proceedings.

Family's Perspective

- Adult A says she has benefitted from ongoing therapeutic support as an adult.

Learning

- Adult safeguarding colleagues considered if they could have offered support to the adults in relation to their care and support needs as part of the investigative and post investigation process.

- It is recognised there is an opportunity to improve systems for communication between Adult and Children Services where there are identified vulnerabilities for both children and adults within the same family.
- Adult safeguarding recognise the need to further develop joint working opportunities with children services.

Summary

What might have been better?

The absence of a clear disclosure where there are child sexual abuse concerns is common. The initial investigation gave a lot of weight to obtaining disclosures from family members. Whilst this was important, it should be recognised that evidence is broader than a verbal disclosure. We know that children are more likely to show us, through behavioural responses, that they are being harmed, rather than telling us. Agencies considered the presenting concerns and anonymous allegations, along with historical information and on balance felt that the threshold for care proceedings was not met. There was nothing at the time that suggested that the behaviour of the children was unusual or concerning. Selective mutism (which was being displayed by one of the children) is a condition that is not uncommon and is not necessarily indicative of abuse. It would not have been possible to pursue DNA testing without the consent of the family; the local authority would have had to go to court seeking an order and the evidence was not deemed by the strategy meeting to be sufficient, or the threshold met to instigate any form of proceedings.

The panel has considered with the advantage of hindsight, that with the availability of current research, knowledge and practice development in child sexual abuse, that alternative action could have been considered in regard to this family at the time of Adult A's earlier pregnancies, when she was still a child and prior to their move to Wales. There were historical concerns regarding Adult A's early pregnancies and lack of knowledge of all of the children's paternity. This was explored at the time, but professionals attending the strategy meetings considered that although the concerns being discussed may have in themselves merited calling a Child Protection Conference, there was no evidence of current harm, nor was it likely to achieve the desired outcome, i.e. a disclosure, was unlikely. The agencies discussed a real concern that the family might also react to a statutory intervention by moving away, as they had done in the past. All agencies acknowledged that there were concerns about this family and were in agreement that ongoing involvement of agencies working with the children and adults should continue for as long as possible. There was a consensus that those agencies seeing the family, including the school safeguarding and attendance team, noted to be a team of qualified and experienced social workers, were well placed to continue to build relationships with the family to try and understand more about the dynamics and issues in the family.

It is worth noting that had more robust child protection actions been taken in England by the agencies involved when Adult A first became pregnant as a child, and subsequently, where the identity of the father was unknown, it may have been possible to have protected her from further abuse earlier. It is acknowledged however that this learning sits outside the remit of this review and relates to historical practice outside the current local authority.

What went well and areas of good practice

From the point of agencies being alerted in March 2018 to the abuse of Adult D by Adult Y, there is evidence of good practice. The detailed timeline shows that agencies followed the correct procedures and guidance in dealing with a child protection allegation as set out in the All Wales Child Protection Procedures 2008[36] and the Social Services and Well-Being (Wales) Act 2014[37], and the local procedures as identified in CYSUR (Mid and West Wales Safeguarding Board for Children) Regional Threshold & Eligibility Document: 'The Right Help at the Right Time'.[38]

The agencies involved had to unravel a long complex historical web of abuse by Adult Y, involving multi-generational intra-familial sexual abuse, coercive and controlling behaviour involving third parties and a spirit adviser/psychic used by Adult Y to control Adult A. There are a large number of children involved and therefore planning for so many children and responding to their individual needs was a huge task. The agencies also had to conduct both criminal and child protection processes dealing with two legal systems. It is therefore commendable to see evidence of such positive practice in the face of these challenges.

Generic good practice identified:

- There is evidence of good communication being maintained within individual agencies and across multi-agency partners.
- There are many examples of 'professional curiosity' being exercised by all agencies throughout the time they have known and worked with the family.
- Cross border working was active across all agencies.
- Ongoing support to all of the family members is exemplary.
- The Welsh Government action plan on child sexual abuse[39] is underway and embedded across Wales and within the CYSUR region.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:

Actions required

Learning has been identified throughout the review process. It is important to note the points below are identified with the benefit of hindsight. Any learning should contribute to improving future practice and ensure services are robust in protecting children. The section below identifies the themes emerging from the review and the learning that can be gained from them.

Action 1

The Mid and West Wales Safeguarding Board for Children (CYSUR) to ensure training is available to practitioners across all agencies in respect of the indicators of child sexual abuse and best practice multi-agency response to both disclosures of and suspected child sexual abuse.

[36] All Wales Child Protection Procedures 2008
[37] Social Services and Well-being (Wales) Act 2014
[38] CYSUR Regional Threshold & Eligibility Document: 'The Right Help at the Right Time'
[39] National Action Plan: Preventing and Responding to Child Sexual Abuse, July 2019

Action 2

The Mid and West Wales Safeguarding Board for Children (CYSUR) to ensure Professional Curiosity Training is available to practitioners across all agencies, to include those who work in preventative services as well as statutory teams where relevant.

Action 3

The Mid and West Wales Regional Safeguarding Board to continue to evaluate the effectiveness of the implementation of the National Action Plan on Child Sexual Abuse, and to continue to promote awareness of the various tools and guidance available to practitioners to support them in safeguarding work where child sexual abuse is disclosed or suspected.

Action 4

The Local Authority school safeguarding and attendance team will develop and implement a system to support designated safeguarding officers in schools to proactively review any safeguarding patterns and trends, including the prevalence of child sexual abuse, which will enable further resources or support to be provided where appropriate.

Action 5

The Local Authority School Safeguarding and Attendance Team will actively promote a Child Sexual Abuse Toolkit developed to support existing training available to education staff in respect of child sexual abuse.

Action 6

Dyfed Powys Police to implement systems and processes:

- To ensure any delays in obtaining antecedent information is acknowledged at an early stage in the Section 47 investigation process and communicated to partners.
- When Police are utilising DNA in such investigations, to ensure that a company suitably accredited for criminal proceedings is utilised.

Action 7

All GP surgeries, where it is possible to do so, to introduce a flagging mechanism to alert all staff to any safeguarding concerns.

Action 8

Adults and Children Services Safeguarding and Social Care Teams to review current systems in place when concerns and vulnerabilities are identified for children and adults in the same family, and identify opportunities to develop and promote clear communication pathways.

Statement by Reviewer(s)			
Reviewer 1	Gladys Rhodes-White OBE	**Reviewer 2** *(as appropriate)*	Diane Beacroft
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)* G Rhodes White		**Reviewer 2** *(Signature)* D.C Beacroft	
Name *(Print)*	Gladys Rhodes-White OBE	**Name** *(Print)*	Diane Beacroft
Date	07/09/2022	**Date**	07/09/2022
Chair of Review Panel *(Signature)*	Holly Gordon		
Name *(Print)*	Holly Gordon		
Date	07/09/2022		

Child Practice Review Process
As outlined, this Review was undertaken in accordance with statutory legislation set out in section 139 of the Social Services and Wellbeing (Wales) Act 2014 and accompanying guidance *Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).* An Independent Panel Chair and two Independent Reviewers were commissioned who were, in accordance with the guidance, independent of the case management and had the relevant experience, abilities, knowledge and skills as required by the case and circumstances under review. The Independent Reviewers and Panel Chair would like to acknowledge and sincerely thank Adult A for her contribution to this review and the practitioners who took part in the learning event, which enabled and supported multi-agency learning to be identified.
Family declined involvement: no

For Welsh Government use only

Date information received: …… *(date)*

Acknowledgement letter sent to Board Chair: ……*(date)*

Circulated to relevant inspectorates/Policy Leads: ……..*(date)*

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix 1

Terms of Reference for Extended Child Practice Review
CYSUR 4/2019

- **Review Panel Chair** – Holly Gordon
- **Independent Reviewer(s)** – Gladys Rhodes-White OBE, Diane Beacroft

Core tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine the effectiveness of inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were in the best interests of the child and outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a multi-agency learning event for practitioners and identify required resources.

For Extended Reviews ONLY. In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about the children and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the children, the family and their circumstances. How did that knowledge contributed to the outcome for the children?
- Whether the child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for those children and their circumstances.
- Whether the plan was effectively implemented, monitored and reviewed. Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?
- What aspects of the plan worked well, what did not work well and why? The degree to which agencies were held to account regarding the effectiveness of the plan, including progress against agreed outcomes for the children. Whether the protocol for dispute resolution was invoked.
- Whether the respective statutory duties of agencies working with the children and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Specific tasks of the Review Panel:

- Identify and commission reviewers to work with the *Review Panel* in accordance with guidance for Extended Child Practice Reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewers and Panel membership.
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewers a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with the individuals and family members prior to the event.
- Receive and consider the draft Child Practice Review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the CPR Sub Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- *Review Panel* members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the CPR Sub Group:

- Agree and approve draft ToR for each case recommended for CPR.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Monitor CPR action plans to ensure all recommendations are carried out on behalf of the Board.

Specific tasks of the CYSUR Safeguarding Children Board:

- Inform Welsh Government of the undertaking of a CPR.
- Adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final

report or the action plan.

- Send report to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them.

Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate.

Confidentiality principles and the importance of adhering to them will be outlined at each Panel meeting to reaffirm the boundaries within which information is being shared:

- In working with sensitive information in relation to a Child Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
    - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 2 – Child Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
    - The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
    - If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
    - However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.