Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

Local Child Safeguarding Practice Review

Overview Report

Mia

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1.0 Introduction

1.1 The purpose of this Local Child Safeguarding Practice Review (LCSPR) is to identify learning with which to improve practice from how partner agencies in a Council within the Children's Safeguarding Assurance Partnership (CSAP) area worked individually and collectively to safeguard five siblings from harm. The siblings ranged in age from 8 months to 16 years and resided in two households. One of the children also spent time in a third household. Mia (not her real name) was the youngest of the siblings and died after becoming submerged in the bath whilst unsupervised by her parents. At the time of Mia's death, her and her sibling's exposure to the risk of sexual harm from her parent's connection with a registered sex offender was being assessed by children's social care.

1.2 CSAP decided to review this case following the death of Mia. CSAP anticipated learning from the response of partner agencies to concerns which began to emerge about the children, from the strength of the interface between safeguarding children arrangements and the management of risks presented by registered sex offenders and the extent to which members of a blended family who reside in different households are seen by professionals as members of the same family. A Panel of managers was established to oversee this LCSPR, chaired by the Designated Nurse from the Clinical Commissioning Group for the local area. CSAP commissioned David Mellor, a retired chief officer of police with nine years' experience of conducting statutory reviews and no connection to local services to be the lead reviewer.

2.0 Terms of Reference and Methodology

2.1 The period covered by the review is from 1st January 2018 until 11th August 2020. Significant events which took place prior to 1st January 2018 have also been considered.

2.2 The key lines of enquiry for the review are:

1. How effective was safeguarding children practice when considering safeguarding risks for a blended family which included three households. This should include:

- Professional's responses to the voice of the children about their lived experience whilst spending time within the different households
- Professional curiosity around the dynamics between the households and adults living in, and visiting, the family home of IPG
- Acknowledging and understanding the reasons why father's older children were reluctant to have contact with him.

2. How effective was safeguarding practice in identifying and responding to Neglect? This should include:

- Professional's recognition and response to Neglect indicators

- Understanding parent's unmet needs and how this impacted on parenting capacity and their ability to prioritise their children's needs and safety
- Professional's understanding of roles and responsibilities and additional early help services that may have been offered

3. How effective was safeguarding practice around Domestic Abuse: This should include:

- Professional's responses to disclosures made by mother around relationship difficulties and understanding the links to coercive and controlling behaviours
- Understanding the lived experience of father's older children who witnessed domestic abuse in their parent's relationship and how this may manifest in father's new relationship.
- The Multi-agency response to reported incidents of Domestic abuse

4. How effective was safeguarding practice around sex offenders spending time within the family home? This should include:

- Professional's response to the risk of sexual abuse of the children living in and visiting the household
- Safeguarding assessments that considered the risk of child sexual abuse (CSA), parenting capacity and parenting ability to protect the children from the risk of CSA
- Assessments that fully demonstrate the lived experience of all the individual children living in and visiting the household
- Information sharing and child safeguarding procedures for sex offender management within Police and Probation services, including when geographical borders are crossed by the sex offender
- Effectiveness of the partnership response, including Child in Need planning, to mother's earlier relationship with registered sex offender 1? (June to September 2017) Were assessments sufficient to ensure mother's learning needs and understanding from this work translated into her capacity and commitment to protect her children from sexual abuse?

5. Did the restrictions imposed as a result of the Covid-19 pandemic have any effect on the single or multi-agency response to this case?

2.3 Agencies which had relevant contact with the family provided chronologies of that contact. A practitioner learning event was arranged to inform this review, which was attended by the following agencies:

- Teaching Hospitals NHS Foundation Trust (Health Visitor, CAMHS and School Nurse)
- Children's Psychological Service.
- Council's Children's Social Care Service.
- GP Practice 1 and 2
- Schools attended by Callum, Connor and Adam.
- National Probation Service

Lancashire Constabulary's Management of Sexual Offenders and Violent Offenders (MOSOVO) team was unable to attend but contributed to the LCSPR through a subsequent interview with the lead reviewer.

2.4 The lead reviewer was also provided with any documents requested.

2.5 Mia's parents ('father' and 'mother') have contributed to this review as have 'father's' former partner - 'mother 2' and her partner - 'father 2'. The eldest of the five children with which this review is concerned – 'Callum' – has also contributed. The views of the family are recorded in Section 4 of this report.

2.6 Further information on the process followed by the Children's Safeguarding Assurance Partnership in deciding how LCSPRs should be conducted can be found at https://www.proceduresonline.com/resources/sgp/p_child_sg_review.html

3.0 Brief summary of the case

3.1 At the time of the incident in July 2020, in which eight months old Mia nearly drowned in the bath in the family home and which led to her death three weeks later, the family composition across three households was as follows:

3.2 Mia's mother and father lived with her, her elder sister Emma aged 22 months and Adam aged 10 years who was mother's son from a previous relationship. Mother and father had lived together for over two and a half years.

3.3 Father also had two children from an earlier relationship – Callum aged sixteen and Connor, who was ten years old. Callum and Connor lived with their mother - who will be referred to as mother 2 in this report – and her partner (father 2). There was considerable conflict between father and mother 2. Callum had a very troubled relationship with father and rarely saw him. Connor had regular contact with father and mother and stayed over at their house but this was also a conflicted relationship. Father fathered six children - Callum, Connor, Emma, Mia and two children who died prior to the death of Mia.

3.4 Mother's son Adam also had contact with his birth father (father 3).

3.5 In June 2017 sex offender 1 targeted a number of families in the Council area in order to have unsupervised contact with children. Mother was groomed by sex offender 1 who had overnight contact with her son Adam - then 7 years old. Children's social care completed a child and family assessment (CAFA) and a child in need (CIN) plan was implemented to safeguard Adam. The plan was closed after mother demonstrated the ability to protect Adam in future.

3.6 By January 2018 father and mother were in a relationship and mother was pregnant with Emma.

3.7 In May 2018 father was successful in obtaining a Family Court direction that Callum and Connor should spend time with him every weekend. The following month children's social care became

involved after Connor – then 8 years old – disclosed that father had injured his foot with a 'recklessly thrown' cigarette. By this time Callum was refusing to spend time with his father. Connor was referred to CAMHS during this period as a result of 'behavioural concerns'. There was a considerable delay in the referral being received by CAMHS and after they referred him to Children's Psychological Services, the latter service was unable to offer him any intervention for over a year.

3.8 Emma was born in September 2018 and Mia was born in November 2019. However, mother and father's relationship had begun to deteriorate and their relationship ended in December 2019 but they continued to live together in the family home, primarily for financial and childcare purposes.

3.9 Mother began a relationship with sex offender 2 during the spring of 2020. In mother's contribution to this review, she denied having an intimate relationship with sex offender 2. Sex offender 2 is a prolific non-compliant sex offender who has targeted multiple women and who may present a risk of sexual abuse to their children. He is also a serial perpetrator of domestic abuse within intimate relationships. Sex offender 2 was also a business partner of father for a time and spent time in mother and father's family home during which it is alleged that he sexually abused Connor whilst the child was staying in the household. There was at least one missed opportunity for agencies to become aware of the involvement of sex offender 2 with mother and father, before a referral from another local authority area disclosed his contact with a number of children in the council area including Connor, Adam, Emma and Mia.

3.10 Children's social care were in the process of completing a CAFA after Connor alleged that he and Adam had been sexually touched by sex offender 2 when Mia was found face down in the bath in which she had been left unattended with Emma by her parents for a number of minutes. Mia was treated in hospital intensive care until her death three weeks later.

4.0 Views of mother, father, mother 2, father 2 and Callum

4.1 Mother and father contributed to the review on the understanding that they would not be asked about the events which led to Mia being found submerged in the bath in the family home given that the criminal investigation into Mia's death had not yet concluded. Mother and father had read a late draft of this LCSPR report prior to contributing to the report. They were spoken to separately.

4.2 Father said he and mother had been let down by services, principally by them 'not listening to a word they said'. He didn't elaborate on this comment.

4.3 He said that he disagreed with most of the LCSPR report, adding that it was 'mostly malicious' and that he perceived the report as a 'vendetta' against him. The late draft of the report father had read included the comments from mother 2, father 2 and Callum. Father said that mother 2 had been making false allegations against him for the past three years. He said she had done this because he had stopped making child maintenance payments for Callum and Connor. He said he had stopped making these payments because the money was being spent on father 2's alcohol consumption and not on his sons. He said he had contacted the Child Maintenance Service and explained why he had stopped making the payments and they had told him that what he had done was correct.

4.4 He said he had only ever put his son Connor first and that his son had always enjoyed being with him. He went on to say that if Connor's mental health was 'so bad' then professionals should ask themselves what was going on in mother 2's home?

4.5 He claimed that Connor's cigarette burn had not been taken any further because it wasn't clear whether it had happened whilst Connor was in his care or whilst the child was in the care of mother 2. Father then slightly contradicted himself by saying that everything that mother 2 said was accepted as the truth but that what fathers say 'doesn't matter'.

4.6 Turning to sex offender 2, father said that when he and mother found out the full truth, they stopped contact straight away. He acknowledged that he had searched the internet for information about sex offender 2 but claimed that all he could find was something from 'ages ago' about sex offender 2 meeting 'a girl in a pub'. Father said that Connor was only in sex offender 2's company once – when they drove to another town to collect a car – and he (father) was with Connor all the time.

4.7 Father said he didn't believe Connor's disclosure of sexual abuse by sex offender 2 and said that mother 2 had put words in his mouth. Father said that he knew this didn't happen because Connor was always in his (father's) care '100%' of the time during which his son visited or stayed at his and mother's house. He went on to say that whenever Connor visited or came to stay he would always arrange for his mother (Connor's paternal grandmother) to be present so that he (father) had got a witness in case mother 2 made any allegations about his care of Connor. Father added that the best thing he ever did was stop contact with Connor as he no longer had to worry about 'what allegations were coming next'.

4.8 Father said he very much appreciated the support he was receiving from the same paediatric bereavement counsellor who had supported him following the sudden death of another of his children.

4.9 Mother said that she had read the LCSPR report. She said that she wanted to make it clear that she was never in a relationship with either sex offender 1 or sex offender 2. She went on to say that the LCSPR report suggested that 'loads of work' had been done with her after her involvement with sex offender 1, when in fact she said she had met 'the woman' three times. She said that the independent social worker who recently assessed her for the care proceedings in respect of Adam and Emma had told her that three meetings were not enough, and she (mother) agreed. Mother acknowledged that she couldn't remember much about the work done with her in 2017 but said that she felt that it didn't leave her with a 'great' understanding of how sex offenders work and what to look out for. She said that if she had had a better understanding she would never have let sex offender 2 into her home.

4.10 Mother said that 'no-one had told them anything' about sex offender 2 in the beginning. She said that he informed them that he was on the sex offender register because he had 'met a girl' who was only 15. He said that he had admitted that he had done wrong and she (mother) thought 'no worries' - at least he'd admitted it. Mother went on to say that, looking back, she should have been

a little ‘wiser’ and ‘put a bit more effort into looking into’ sex offender 2. She said that woman B stayed at her house so that sex offender 2 could ‘see his little boy’. (Woman B was a vulnerable care leaver who had given birth to sex offender 2’s baby in late January 2020). However, mother said that she eventually had enough of this arrangement as she (mother) ended up doing all the cooking and cleaning. Mother claimed that sex offender 2 – who she referred to by a shortened and familiar version of his first name – had never touched any of her children because she would ‘never allow it’.

4.11 Mother said that it became ‘too much’ to have Connor stay with her and father each weekend, and that they had stopped this arrangement because he was ‘kicking off’, causing arguments ‘for the sake of it’ and threatening to hurt Adam and Emma. Mother said that Connor had not stayed overnight with her and father since December 2019. She went on to say that he continued to visit their house until late February 2020 and that the only time he had met sex offender 2 was when he and father had accompanied sex offender 2 to another town to collect a car.

4.12 Mother said that Connor had been ‘prone to lie’ in order to be ‘the centre of attention’ and if sex offender 2 had abused him, mother said that she would have expected Connor to disclose this at the time and not ‘months and months down the line’.

4.13 Mother said that she felt let down by the health visitor for Emma and Mia. She said that the health visitor had said her house was dirty and cluttered. Mother said she accepted that it was always cluttered but never dirty. She said she was also unhappy that the health visitor had said that Emma was left alone in the room in which the dryer was situated – in which potentially dangerous machinery was stored. Mother rejected this, saying that Emma helped her put clothes in and take them out the dryer. Therefore Emma had become familiar with the operation of the dryer but that this did not mean she was ever allowed to go into the room with the dryer on her own.

4.14 Mother acknowledged that father could be ‘slightly controlling’. She also said that mother 2 had kept taking father to court because she ‘liked to cause dramas’. Mother also accused mother 2 of ‘putting hate in her kids’.

4.15 Overall, mother felt that she had been honest throughout but that now everyone was trying ‘to kick her when she was down’.

4.16 Mother 2, father 2 and Callum contributed to the review via a telephone conversation with the lead reviewer.

4.17 After she left him in 2017, mother 2 said that father rang children’s services constantly to raise concerns about her and her partner’s parenting of Callum and Connor and children’s services followed them all up. She contrasted this with the response to her calls to children’s services, the NSPCC and the police to raise concerns about how father treated Connor and she felt that no-one followed up or helped the family in any way other than the referrals for support for Connor’s mental health. The contrast which mother 2 highlights here may indicate a tendency for professionals to focus on mothers as the primary providers of care to children and underplay a father’s parenting responsibilities.

4.18 She said that she and her partner felt that it would take something serious happening before services took their concerns seriously. In the event, they felt it took Connor's disclosure of sexual abuse and the death of Mia before services began to appreciate the harm children in the care of father could come to. Mother 2 said that when these events took place, the attitude of children's services towards her and her partner 'suddenly' changed and they wanted mother 2 to help them out.

4.19 Mother 2 felt that the concerns she expressed on behalf of her sons weren't listened to by children's services or the Family Court Judges. Callum also felt that he and his brother had not been listened to by children's social care, the Court and CAFCASS.

4.20 After mother 2 and father's relationship ended, mother 2 said that Callum didn't want to see father whilst Connor wanted to see him but didn't want to stay overnight with him.

4.21 Whilst staying with mother and father, mother 2 said that Connor suffered a cigarette burn from a cigarette thrown towards him by father, had an ashtray thrown at him which fortunately did not hit him but 'smashed into pieces' and caught scabies* from sleeping in dirty hotel beds. She said that father was managing hotels at the time and he and mother would move from one hotel to another. They would sleep in the flat provided for the manager but the children would often sleep in guest rooms. She said that Connor and Adam often shared a guest bedroom and the doors were not locked so it was possible for other people staying in the hotel to gain access.

*The only reference to scabies in the chronologies submitted to this review relates to a GP attendance in July 2020 although Connor was taken to the GP in June 2018 with a skin rash suspected to have been caused by insect bites, which could have been seen as an indicator of parental neglect.

4.22 Mother 2 said that she stopped contact between Connor and father in 2018 and again in 2019 because the child was always 'in a state' when he returned home. She went on to say that she finally put a stop to Connor staying with his father in March 2020, after Connor told her that when he was out with his father, he felt like jumping out of the car and running away. Mother 2 said that she didn't know at the time but this was around the time that Connor had allegedly been sexually abused.

4.23 Mother 2 said that Callum last saw father at Christmas 2018 when she had to collect her sons after father and mother tried to force Callum – who was 14 – to drink alcohol. Callum said that father and mother had both been drinking and they continuously tried to persuade him to drink alcohol. He refused because he didn't want to but added that he was also conscious that there were younger children in the care of father and mother, including 3 month old Emma so he felt that someone needed to be sober and responsible. However, he said that father and mother simply wouldn't take 'no' for an answer and kept pushing alcohol towards him and applying ever greater pressure. He said that mother 2 picked him up and he resolved never to stay with father again.

4.24 Callum said that, prior to that, he had felt forced to go and spend time with father and said that he 'absolutely hated it'. He said that he was old enough to make sure that he went as infrequently as

possible but Connor was younger and didn't have any choice. He reiterated that he and Connor spent quite a lot of time staying in the hotels his father was managing. They would stay in very small rooms and he said that he would be expected to clean the room before they went into it. He said that the hotels and the homes father and mother lived in were very unclean and their homes were an 'absolute mess' because, in his view they didn't care. From the time he lived with father, before father and mother 2 split up, he knew what father was like, everywhere was a mess, father's stuff was everywhere in every room – car parts, DJ equipment and loose tools including very heavy tools.

4.25 Callum went on to say that he had now cut father out of his life and changed his surname from that of his fathers. He said that he just didn't want to be around him because father's priority was always what he was doing, he couldn't care less about anyone else, he was always drunk, always 'kicking off', being controlling and manipulative and he would leave his kids with anyone. Callum added that this was the way his father had been as long as he could remember.

4.26 Reflecting on her life with father, mother 2 said that he was violent towards her at times but was continually verbally abusive calling her a 'slag' and a 'slapper'. She said that she was never allowed money or a bank card and that father wouldn't leave her any cigarettes when he went out. She said he would also hide the car keys so that she couldn't drive anywhere unaccompanied. Mother 2 said that father was verbally abusive to the children as well, calling them 'thick', 'stupid' and saying that 'they would never be any better' and just 'bringing them down' every day. She said that he also used to hit them.

4.27 She said that she eventually found the strength to leave him, adding that she keep everything secret and found another house 'behind his back'. She said her mother helped her to move out.

4.28 Callum supported mother 2's account of her relationship with father. He said that father never let mother 2 go out with friends and when she went to college, he accused her of 'sleeping around'. He said that father never let mother 2 go out with money and that he would always have to go with her to spend the money himself. He recalled helping father when he was DJing and feeling he had no choice. He said father would always say that he would give him money for helping him, but never did. Callum said that father never allowed him to go out with friends but added that he never wanted to invite friends over to his house anyway because he didn't want them to see what it was like.

4.29 Mother 2 said that since he had not had to have contact with father, Connor was 'like a different child' and his only worry was that he might be forced to see father and mother again. He also had expressed a wish to change his surname.

4.30 Father 2 largely confirmed what mother 2 and Callum had said. In father 2's opinion, father 'emotionally tortured' Callum and Connor including threatening to kidnap them and to break into mother 2's house and take all their things including the TV and playstation. Father 2 said that Connor still slept with his bedroom light on and with the bedroom door open because of these threats from his father. Father 2 said that father told Connor to 'play up' at home and he would reward him for it.

4.31 It is clear that considerable conflict has developed between father and mother and mother 2. In their contributions to this review they have provided accounts which contradict each other. However, mother 2 and Callum provided fuller accounts which were more consistent with the information recorded by agencies. Father's contribution to the review was very brief and strained credulity at times, particularly his claim that children's social care were unable to determine whether the cigarette burn to Connor took place at father's home or mother 2's home and his assertion that the Child Maintenance Service had approved of his refusal to pay child maintenance for Callum and Connor.

5.0 Analysis

5.1 In this section of the report each key line of enquiry will be addressed.

1. The effectiveness of safeguarding practice when considering safeguarding risks for a blended family which included three households, including:

- **(a) professional's responses to the voice of the children about their lived experience whilst spending time within the different households**
- **(b) professional curiosity around the dynamics between the households and adults living in, and visiting, the family home of Mia**
- **(c) Acknowledging and understanding the reasons why father's older children were reluctant to have contact with him.**

5.2 Professionals appear to have gained the greatest insight into the lived experience of Connor. His time in mother and father's household seems to have been uncomfortable for him and punctuated by periods when either he did not visit, or his visits were curtailed for a time. Father went to a great deal of effort to have his right to contact with Connor upheld but Connor felt that father didn't show much interest in him when he visited and there is the suspicion that father exerted his rights to contact with Connor to send a message to mother 2 that she wasn't free of his controlling behaviour. Connor may also have experienced pressure from mother 2, who attributed his outbursts of anger in the home he shared with her and father 2 to his adverse relationship with father. Mother didn't appreciate Connor's presence and Adam appeared to resent the arguments which ensued between mother and father when Connor visited. Additionally, after Connor presented with 'behavioural issues' Connor was left without emotional wellbeing/mental health support for in excess two years despite a referral to CAMHS and then an onward referral to Children's Psychological Services.

5.3 Adam may have been exposed to poor home conditions and drug dealing from the family home as a young child living with mother and father 3, although these anonymous concerns were not substantiated by children's social care. He was twice exposed to risk from registered sex offenders who groomed mother and had access to him at the age of 7 – when fairly intensive support was provided to him over a three month period - and at the age of 10. It is not known whether the support provided to Adam when he was first exposed to the risk of sexual harm may have helped him to keep safe from sex offender 2 when the latter began visiting the family home. These two episodes may also have shaken his trust in adults who came into his life. Adam's school was

represented at the practitioner learning event and noted that he had not shared any concerns in school and questioned whether he had normalised high risk situations to the point that his school was unable to pick up on them.

5.4 Otherwise Adam does not appear to have been particularly visible to professionals. Mother and father appear to have sometimes relied upon him to supervise Emma and Mia at bath times which was inappropriate given his young age. Adam's relationship with Connor, who was the same age as him, appears to have been conflicted. For two children of the same age, there appears to have been much less contact between Adam and his GP practice than Conner which may reflect, in part, a different approach to seeking support for their children by the respective parents.

5.5 Emma was the first child of mother and father's relationship, but that relationship was under strain by the time of her birth. It seems likely that she became accustomed to either witnessing arguments between her parents or experiencing tension between them. It is unclear how emotionally available mother was for Emma - and later Mia - given her largely self-managed depression. Mother worked night shifts in a nursing home and so she may have been sleep deprived when caring for the child. In theory father was often Emma's primary carer although mother commented to the health visitor on the lack of support he gave her. Emma experienced a number of house moves, requiring her to adapt to changing environments which were often cluttered and sometimes dangerous. By the time of Mia's birth, mother and father's relationship was practically over and so Mia seems unlikely to have experienced parental harmony during her short life. Both she and Emma will have become accustomed to other adults visiting and staying in the house including sex offender 2 and a woman (Woman B) and a baby fathered by sex offender 2 who were known to another Local Authority Children Social Care Service due to their ongoing association with sex offender 2. It seems unlikely that hers and her sister's needs were afforded sufficient priority by her parents or the visiting adults. Mother and father used Cannabis which may have affected their parenting capacity, including on the evening when Mia became submerged in the bath. The sudden disappearance of her younger sister from her life may have been traumatic for Emma, particularly as mother and father initially blamed her for Mia freeing herself from the seat in which she had been placed in the bath. Achieving any greater insight into the lived experience of Mia and Emma has been limited by the minimal records kept of their presentation by the professionals who came into contact with them, although it is accepted that the professionals who saw Mia and Emma were primarily providing them with a universal service.

Recommendation 1

That CSAP reminds professionals of the importance of documenting how a child is presenting and the interaction between the child and parent/carer in order to better understand the child's lived experience.

5.6 Callum stopped visiting his father but lack of physical proximity to his father seems unlikely to have insulated him from the effects of the continuing conflict between mother 2 and father and Connor's unenviable position somewhere in the midst of these arguments. Callum was coming to terms with his sexuality, an issue on which he does not seem to have been supported by father. What may have lay beneath Callum's self-harming and what were described as 'suicidal' social media

post (s) is suggested by the information Callum has shared with this CSPR (Paragraphs 4.24, 4.25 and 4.28)

5.7 The increase in blended families reflect profound societal changes. The Census counts 'stepfamilies' – defined in the 2011 census as 'couple families' including at least one stepchild. Stepfamilies accounted for 4.5% (717,000) of all families in England and Wales in 2011 (1). It is assumed that mother and father's family would be classed as a 'stepfamily' for census purposes as Adam would be classed as a 'stepchild' of father. Questions 1a and 1b focus on the need for professional curiosity to understand the dynamics between the households of a blended family including understanding the lived experience of the children whilst spending time within different households. The practitioner learning event arranged to inform this CSPR brought together professionals who had knowledge of one or more of the children but were less aware of the lived experience of the same children when they were visiting or staying in different households in the same blended family. Professionals were sometimes unaware of the composition of the blended family and the potential impact that events which took place in one household had on other households in the same blended families. Feedback from the professionals who attended the learning event suggested that this was a key area of learning for them.

Recommendation 2

That when CSAP disseminates the learning from this case, the opportunity is taken to emphasise the importance of understanding the lived experience of children in blended families, particularly when they are visiting or staying in different households within the blended family.

5.8 Understanding the lived experience of children within blended families depends to an extent on 'professional curiosity', but in order for professionals to be able to be curious, systems need to be in place which support professionals to observe children's links with more than the household in which they are resident. In the case of children's social care, their Record System MOSAIC has children's demographic pages which have a 'relationships' section which presents links to extended family members outside of the family home (children's extended family & social networks), previous child deaths which children's social care have been informed of and other non-household and non-family members and associations, in this case sex offender 2. By clicking onto sex offender 2's demographic page, his relationships section presents the other women and children he is known to have had associations with together with children's social care involvement with the individual respective children. Also the Children and Family Assessment template includes guidance notes advising the professional conducting the assessment to consider the child's family and social networks. This template was revised and implemented March 2020 and a total of 379 Children's Services staff have received training from the Principal Social Worker and a member of their Systems Team over the past twelve months.

5.9 However, the Contact and Referral form completed by children's social care when concerns first arose about the risk presented to mother and father's children by sex offender 2 showed an incorrect address for Emma and Mia's address was documented to be 'unknown'. This suggests that systems for gathering or possibly updating address details for children – following the January 2020

house move (Emma) or following her birth (Mia) – may be less than fool proof. Incorrect address information could create confusion over precisely who the child is living with.

5.10 Mother, Adam, Emma and Mia were registered with a different GP practice to father who remained registered with the same GP as Callum, Connor and mother 2. The fact that father did not register with mother's GP practice reflects his personal choice. However, this review has been advised that father's GP practice did not link him with Callum and Connor, which is concerning given that their surnames had been the same (although Callum informed this review that he has since changed his surname to further distance himself from father). This CSPR has been advised that GP practices automatically link a mother with her children but that there is not an equivalent automatic approach in respect of fathers.

5.11 The CSPR Panel also felt that school admission systems could be enhanced to gain a better understanding of additional significant adults in a child's life together with details of half-siblings and step-siblings. These and other proposals form single sector recommendations for Education which are shown in Appendix A to this report.

Recommendation 3

That CSAP request all partner agencies to review their information systems in order to consider what changes may be necessary to facilitate professional focus on children in blended families who may move between households or may be affected by events which take place in a household in which they do not normally reside.

2. The effectiveness of safeguarding practice in identifying and responding to neglect, including

- **(a) professional's recognition and response to neglect indicators**
- **(b) understanding parent's unmet needs and how these impacted on parenting capacity and their ability to prioritise their children's needs and safety**
- **(c) professional's understanding of roles and responsibilities and additional early help services that may have been offered**

5.12 Neglect may involve a parent or carer failing to

- provide adequate food, clothing or shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate caregivers)
- ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basis emotional needs (2).

5.13 The circumstances of Mia's near drowning, which led to her subsequent death, indicate a failure to protect from danger and a lack of adequate supervision. Allowing sex offender 2 to spend time in their home and have unsupervised access to their children, was also a failure to protect by father and mother which will be addressed later in this report.

5.14 However, indications of parental neglect arose prior to the incident which led to the death of Mia, in particular the dangers faced primarily by Emma as a mobile child following the house move in January 2020, given the health visitor's concerns about the storage of heavy tools, metal ladders and other equipment in the dining room. In his contribution to the CSPR Callum described father's homes as an 'absolute mess' with his father's stuff 'everywhere in every room', including car parts, DJ equipment and loose tools including very heavy tools (Paragraph 4.24). Additionally, the Rapid Review of this case, which preceded this CSPR stated that whilst she was being treated in hospital following the near drowning incident, nursing staff found a drawing pin in Mia's nappy. It was thought that she ingested this prior to the incident and it was suggested that other foreign objects were in her stomach, although that had yet to be positively confirmed. Although the health visitor was told by mother that Emma was not allowed to go into that room, she had good reason to doubt mother's honesty on this point. There could have been greater professional challenge at this time.

5.15 There could also have been greater curiosity about the sleeping arrangements for new born Mia who was sleeping in a Moses basket in the lounge with her parents. It was unclear why the baby was sleeping in the lounge with parents in a detached house.

5.16 Mother and father moved house on more than one occasion during Emma and Mia's lives, including the January 2020 house move. Father also managed a number of hotels which appeared to necessitate frequent moves from one hotel to another. There may have been opportunities for professionals in contact with the family to have explored their living arrangements during this period. House moves and temporary housing are amongst the factors identified as 'situational risks' which can lead to unsafe sleeping environments for infants in the National Child Safeguarding Practice Review Panel's review 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (3).

Recommendation 4

That CSAP ensures that 'situational risks' such as house moves and temporary housing are highlighted in the local response to the learning about sudden unexpected deaths in infancy highlighted by the National Child Safeguarding Practice review's report.

5.17 After mother gave birth to Emma in Autumn 2018, indications of mild depression were noted by the health visitor. Mother saw her GP in January 2019 and said she was feeling depressed for which she was prescribed antidepressants. It is understood that mother's prescription of antidepressants was short-lived, probably because of her pregnancy with Mia. Her GP also referred her the single point of access for mental health services in April 2019. However, the single point of access has no record of receiving any such referral.

5.18 By October 2019 the health visitor noted that mother was 'self-managing' her mental health although difficulties in her relationship with father over his infidelity, the lack of support he gave her and arguments arising from Connor's visits, were causing her stress. When the health visitor saw mother the following month (November 2019) mother said that she was feeling 'overwhelmed' which the health visitor did not feel was unusual for a new mother. She disclosed that her relationship with father remained 'difficult'. When she saw mother in late December 2019, mother

agreed to complete the PHQ-9 Depression Questionnaire which disclosed severe depression. Mother was described as tearful and wanting to end her relationship with father but being unable to do so as 'neither of them had anywhere to go'. The health visitor referred mother to Supporting Minds – which offers brief psychological treatment for depression and anxiety disorders – but that service has no record of mother ever accessing the service. When the health visitor later asked mother if she had made contact with Supporting Minds, she said that she hadn't. It appears that Supporting Minds rang mother, did not receive a reply and she did not return the call.

5.19 It is possible that father may have had unaddressed mental health issues. He was reported to have attempted to take his own life by throwing himself into the sea four months after the death of one of his children with mother 2 in 2008. It is now known that father received bereavement support at that time. In June 2020 father is also said to have left the home he shared with mother in a 'suicidal state' after an argument with mother, before later being found safe and well at the sea front by the police. His GP practice was represented at the practitioner learning event and they suggested that father's statements about self-harming could also be seen as manipulation. He was never referred to mental health services.

5.20 Mother and father may have benefitted from the offer of Early Help following the birth of Mia in November 2019. Their needs appeared to largely correspond to the 'Level 2 – Universal Plus' level of need - set out in 'Working Well with Children and Families in Lancashire' - at which the offer of Early Help should be considered in that they appeared to require extra help to meet the specific emotional needs of mother, to respond to the short term crisis occasioned by the breakdown in mother and father's relationship and to improve their parenting. Had mother and father consented this would have led to an early help assessment which could have helped to support the family and increase the visibility of the range of issues affecting the family, and the wider blended family including father's controlling and coercive behaviour towards mother, mother 2 and Connor.

Recommendation 5

That CSAP seek assurance that the principles of 'Working Well with Children and Families in Lancashire' are consistently applied and that Early Help is offered where appropriate.

3. The effectiveness of safeguarding practice around domestic abuse, including:

- **(a) professional's responses to disclosures made by mother around relationship difficulties and understanding the links to coercive and controlling behaviours**
- **(b) understanding the lived experience of father's older children who witnessed domestic abuse in their parent's relationship and how this may manifest itself in father's new relationship.**
- **(c) the multi-agency response to reported incidents of domestic abuse**

5.21 There was a history of domestic abuse in father's relationship with mother 2. Reported incidents were primarily verbal disputes but there were also reported incidents of domestic violence in which father was the perpetrator.

5.22 After he and mother 2 separated, father's conduct towards her and their children Callum and Conner indicated a degree of coercive and controlling behaviour. During 2017, father 2 began reporting concerns to children's social care about mother 2's ability to parent Callum and Connor. Despite these concerns not being substantiated by children's social care, he continued to raise them.

5.23 In 2018 father was successful in obtaining a Family Court direction that Callum and Connor should spend time with him every weekend. By this time father was living with mother. However, both sons were reluctant to spend time with their father and Callum, who was 14 by this time, increasingly avoided contact with his father. Connor, however continued to visit and stay with father and mother and his foot was injured by a cigarette 'recklessly thrown' by father in June 2018 which prompted children's social care involvement which is understood to have consisted of an assessment, CiN plan and Family Group Conference. Following the Family Group Conference, it was stated that the family had a plan to make positive changes. It is unclear who was seen as Connor's 'family' at that time. It had been hoped to view the record of the Family Group Conference in order to understand who was perceived to be Connor's 'family' at that time, but the record is no longer available as the provider of Family Group Conferences was externally commissioned at that time. Family Group Conferencing is no longer externally commissioned.

5.24 On 27th July 2018 Connor was referred to CAMHS by a consultant paediatrician because of what were documented to be 'behavioural issues' ('behavioural issues' as a term is unhelpful as the behaviours he was displaying appeared to have arisen because he had witnessed domestic abuse) who subsequently referred him to Children's Psychological Services. Connor did not begin receiving a service from Children's Psychological Services until 14th August 2020. This was an unacceptably long delay for a child to wait for support in respect of their emotional wellbeing/ mental health. In all the delay amounted to 29 months because the hospital consultant paediatrician promised mother 2 that they would make a referral to CAMHS in March 2018 but there is no record of any referral at that time. Not having heard anything from CAMHS, mother 2 raised the issue with her GP who did not wish to duplicate the consultant's CAMHS referral. The GP practice did leave a message with the consultant's secretary but there is no indication that a reply to this was received. On 26th July 2018 Connor was seen by a different hospital paediatrician who noted that the CAMHS referral had not been completed in March 2018 and so this second paediatrician completed the CAMHS referral. However, CAMHS state that they did not receive the referral from paediatrics until 28th January 2019. The referral was accepted and a 'choice' assessment was completed on 24th April 2019. Connor's case was discussed in CAMHS MDT on 1st May 2019 and it was agreed that a referral to Children's Psychological Services was the most appropriate way forward. On 16th July 2019 Connor attended an initial access appointment with Children's Psychological Services following which he was placed on an internal waiting list pending allocation to a clinician. The clinician wrote to Connor's parents to advise that they (the clinician) would be the named contact whilst Connor was waiting and also advised that they could self-refer to the local parenting course provided by 'The Carers Centre'. In May 2020 Connor was seen by his GP for anxiety and it was noted that he had yet to receive a service from Children's Psychological Services and a further CAMHS referral was considered by the GP at that point. The GP practice contacted Children's Psychological Services to express concern about the length of time Connor had been on their waiting list. Children's Psychological Services have advised this review that they have no record of the GP contact. In July 2020 Children's Psychological Services attempted to contact mother 2 via telephone to commence

an intervention however her contact details were out of date. This led to a further delay until correct details were obtained from Connor's social worker in August 2020. As stated Connor attended his first intervention appointment on 14th August 2020.

5.25 There are a number of points in the above sequence when professional practice could have been improved particularly the omission by the first consultant paediatrician in not submitting the CAMHS referral, the partial follow up by the GP when mother 2 had heard nothing and the lack of response to the GP's enquiries by the hospital, the lack of more persistent follow-up by the GP practice at that time, the unexplained gap of six months between the submission of the CAMHS referral by the second consultant paediatrician and it's receipt by CAMHS and the 13 months Connor spent on the waiting list for intervention by Children's Psychological Services. The decision to refer Connor to Children's Psychological Services by CAMHS appears to have been a sound one, despite the concerns expressed at the practitioner learning event that CAMHS tend not to accept referrals where the source of the child's distress appears to be 'situational'. In Connor's case it is understood that his 'behavioural issues' were attributed to domestic abuse. A CAMHS manager has advised this review that her service supports high numbers of children with behavioural concerns and co-existing mental ill health and distress, and work closely with children's social care. She went on to say that the 'real issue' is that CAMHS is commissioned and funded for mental ill health as its priority and there isn't a local Behavioural Support service, nor even a Learning Disability and Autism service and so CAMHS can become the default place to go. The CAMHS manager also advised this CSPR that a key factor in Connor's long wait for Children's Psychological Services is the number of unfilled posts in that service. Children's Psychological Services have advised this review that due to the small size of their team they are disproportionately affected by any vacancies or long term absences. They also point out that there is currently a national shortage of qualified Clinical Psychologists to which Heath Education England have responded by increasing training places in 2020 and 2021. Children's Psychological Services has made a number of unsuccessful attempts to recruit to the current 1.0 whole time equivalent (wte) vacancy. In localities where Lancashire and South Cumbria NHS Foundation Trust (LSCFT) is the provider for both Children's Psychological Services and CAMHS, the two services have been fully integrated into one team, which is not currently an option locally due to the services being commissioned by two different NHS providers. This review has been advised that the staffing pressures on Children's Psychological Services is on the risk register of LSCFT.

5.26 The CSPR has been advised that there is now one SPA for CAMHS and Children's Psychological Services which should improve co-ordination and information sharing although the services have different information systems. The learning event was also advised that whilst waiting for a specific psychological intervention, children/parents/carer will now receive monthly telephone/online contact from a clinical staff member in Children's Psychological Services. All young people accepted into the service are allocated to a named clinician for assessment. This clinician then usually takes on the care coordinator role to ensure consistency of support and oversight of any care recommended by the service. Care coordination roles include: being a named contact for parents to speak to outside of planned appointments, referral to any other support services required, and providing the family with advice on other local services and/or online information they may wish to access to support their child. Care coordinators ensure that the monthly contact with families on internal waiting lists includes discussion of any changes which might impact on the child's care plan.

5.27 Notwithstanding the long delay in offering support to Connor, it may have been possible for his GP to posit a link between the emotional difficulties he was presenting with and the trauma he experienced witnessing domestic abuse between father and mother 2 and the emotional abuse arising from having no choice but to visit and stay with father when he became increasingly reluctant to do so. There may have been opportunities for contact between the GP, Connor's school and the consideration of Early Help.

Recommendation 6

That CSAP seeks assurance from Lancashire and South Cumbria NHS Foundation Trust over the steps being taken to reduce waiting times for Children's Psychological Services and also seeks assurance over the effectiveness of the monthly telephone/online contact provided to children and their families whilst on the waiting list.

Recommendation 7

That CSAP seeks assurance that GP's work with partner agencies to consider alternative approaches to supporting children who present with 'behavioural issues' before making a referral to CAMHS.

Recommendation 8

That CSAP considers the implications of a lack of a local Behavioural Support Service (and Learning Disability and Autism service – as reported on in previous CSPR for Ryan, Nathan and Amelia) and decides any action which may be necessary.

5.28 In September 2019 the Family Court again considered Connor's contact arrangements with father after the latter had made application to enforce the previously agreed arrangements for Callum and Connor to spend time with him. Connor told CAFCASS that he wanted his parents to stop arguing, he wanted to have fun when spending time with his father as they didn't do a lot together and he wanted to spend the day with him rather than staying overnight at the weekend. CAFCASS has advised this review that from reading the notes of their family court advisor's (FCA) conversations with Connor, there were times when it appeared that Connor had been told what to say to the FCA by his father. The Section 7 report completed by the Local Authority Children's Services recommended that Connor should not stay overnight with father until he was receiving support from Children's Psychological Services. The Section 7 report acknowledged 'the emotional pressure he was under and the necessity for psychological input to address his emotions and behaviour'. It was good practice to delay overnight stays until Connor was receiving support from the Children's Psychological Service. (Children's Psychological Services has advised this review that they would not support providing therapy to a child to enable contact if the emotional and behavioural issues resided within the parent's own behaviour towards the child).

5.29 In March 2020 mother 2 and father 2 attended a police surgery to report that Connor disliked attending father's address so much that he had 'threatened suicide' because father told him that mother 2 didn't love him and that she was a drug dealer. Additionally, Connor had been left in the care of a female he didn't know whilst father and mother were out (possibly Woman B – see later).

The police advised mother 2 to seek legal advice and passed what she had told them to children's social care. Children's social care noted that there had previously been counter allegations by father (although the CSPR has been advised that these counter allegations had been assessed and considered to be unfounded). Children's social care established that mother 2 was doing everything she could to safeguard the children and was currently preventing contact with father. She was to seek legal advice with regards to contact between the boys and their father. The matter was ultimately considered to be a Family Law matter and no further action was taken.

5.30 In May 2020 Connor was referred to the MASH by his GP after mother 2 reported him to be anxious, tearful and unusually quiet. He said that he no longer wanted to visit his father. It seems possible that Connor's presentation at that time was linked to his later disclosure that he had been sexually abused by sex offender 2 whilst staying at father and mother's address. The MASH decided that appropriate services were in place to support Connor. However, the MASH did not link Connor to the recent (25th April 2020) concern that mother had entered into a relationship with sex offender 2. (Children's Psychological Services have advised this review that they were not made aware of this new information regarding harm to Connor until August 2020. Therefore, their assessment of his presenting needs remained unchanged from the first appointment attended in 2019).

5.31 As he got older, Callum was largely able to avoid visiting father and mother, although the Family Court proceedings initiated by father may have made him fearful that he would be obliged to spend time with him. Unknown to both mother 2 and father, Callum may have been self-harming for the three years prior to September 2019 and began posting material on social media which was described as 'suicidal'. A factor which appears to have contributed to Callum's distress was his father's 'struggle' with his son's sexuality.

5.32 in their contribution to this CSPR mother 2, father 2 and Callum have described the manner in which they say father manipulated and controlled mother 2, Callum and Connor. It was clear that they feel considerable antipathy for father. However, their account is consistent with the behaviour noted by agencies such as the police (Paragraph 5.33) children's social care, CAFCASS and Children's Psychological Services (Paragraph 5.52). Looking back at the case agencies could have given greater emphasis to the indications of coercive and controlling behaviour by father towards mother 2.

Recommendation 9

When the learning from this CSPR is disseminated CSAP take the opportunity to highlight the many, often subtle forms which coercive control can take in intimate and familial relationships.

4. The effectiveness of safeguarding practice around sex offenders spending time within the family home, including:

- **(a) professional's response to the risk of sexual abuse of the children living in and visiting the household**
- **(b) safeguarding assessments that considered the risk of child sexual abuse (CSA), parenting capacity and parenting ability to protect the children from the risk of CSA**
- **(c) assessments that fully demonstrate the lived experience of all the individual children living in and visiting the household**

(d) information sharing and child safeguarding procedures for sex offender management within Police and Probation services, including when geographical borders are crossed by the sex offender

(e) effectiveness of the partnership response, including Child in Need planning, to mother's earlier relationship with registered sex offender 1. (June to September 2017) Were assessments sufficient to ensure mother's learning needs and understanding from this work translated into her capacity and commitment to protect her children from sexual abuse?

5.33 On 25th April 2020 mother contacted the police after receiving approximately 30 text messages from father whilst she was at work. Father told the police that he had sent the texts out of concern that mother was in a relationship with sex offender 2, who he believed to be a 'paedophile' and pointed out media reporting to this effect he had found on the internet. Mother denied being in a relationship with sex offender 2, who is a prolific non-compliant registered sex offender who had been living in the area since his release from prison in October 2019 and was being supervised by the National Probation Service (NPS) and also managed by Lancashire Constabulary MOSOVO (Management Of Sexual And Violent Offenders). At that time sex offender 2 was also known to children's social care in the area because of his relationship with a Woman B in respect of whose children there was a child protection plan from March 2019 until April 2020.

5.34 Father later said that he had been mistaken in alleging mother was in a relationship with sex offender 2. The police had made a referral to children's social care who initially considered a CAFA to be an appropriate response but after father's retraction, they decided that there was no role for themselves and took no further action.

5.35 This was a missed opportunity to properly consider whether the children in mother and father's household were at risk of sexual harm from sex offender 2. The Contact and Referral record completed by children's social care has been shared with this review. Mother's 2017 relationship with sex offender 1 was considered but there is no indication that children's social care's knowledge of sex offender 2's relationship with woman A was considered. MOSOVO became involved and contacted sex offender 2 to ask him if he was in a relationship with mother, which he denied, which appeared to be accepted at face value. The NPS do not appear to have been invited to contribute information to children's social care's decision making although they were no longer supervising sex offender 2 by this time. At that time, NPS was aware of sex offender 2's relationships with woman A and was also aware of his friendship with father's brother, his friendship/relationship with father's brother's ex-partner and the business partnership with father.

5.36 The police became aware, or were reminded, that father considered himself to be sex offender 2's business partner when they were called to an incident in which a former partner of sex offender 2 damaged two of his cars. By this time (12th June 2020) sex offender 2 had been arrested and was in prison on remand. There is no indication that any link was made to the 25th April 2020 incident.

5.37 Children's social care and their partners were only able to establish the truth about mother's relationship with sex offender 2 and gain an understanding about his access to her children after a referral from children's social care in another Local Authority area on 18th June 2020. This referral

was followed shortly afterwards by a disclosure from Connor that he had been sexually abused by sex offender 2 whilst staying at father and mother's address. It was also learned that mother had sent a naked image of Emma to sex offender 2. There is no indication that any of the other children living with mother and father were sexually abused by sex offender 2.

5.38 It was whilst children's social care were carrying out a CAFA following the concerns that mother and father's children had been exposed to the risk of sexual harm, that Mia was found face down in the bath in which she had been left unattended by her parents alongside her sister Emma.

5.39 The CAFA was initiated following the referral from another local authority area (Paragraph 3.9) and Connor's disclosure that he had been sexually touched by sex offender 2 (Paragraph 3.10). A strategy meeting took place on 29th June 2020. Section 47 enquiries were completed by 2nd July 2020 and the CAFA was begun. The target date for completion of the CAFA was 10th August 2020. On 19th July 2020 Mia was found face down in the bath after she and Emma had been left unattended in the bath by mother and father. During the three weeks prior to this near drowning incident, children's social care had substantial contact with mother and father. Clearly children's social care had serious concerns about mother and father allowing sex offender 2 to spend time in their house although both parents claimed at this time that sex offender 2 had not had unsupervised access to their children. A safety plan was put in place in which comfort was taken from the fact that sex offender 2 was in prison and was therefore assumed to present no risk to the children. This was an inappropriate assumption to make given the potential for contact between mother and father and sex offender 2, albeit it was only later that this contact was found to have taken place. Children's social care were not concerned about home conditions during this period. Father and mother presented as a couple who were in a relationship which was later found to be false. Clearly there would have been reservations about mother's capacity for change given the work done with her when she had a prior relationship with sex offender 1 in 2017. However, given the fact that the CAFA was incomplete and that father and mother's dishonesty in presenting as a couple and claiming not to have allowed sex offender 2 unsupervised access to their children was yet to be established, and that at that time, home conditions were not a cause for concern, there were no further steps which children's social care could have taken at that time which could have contributed to preventing the near drowning incident which led to the death of Mia.

5.40 The direct relevance of the exposure of the children to the risk of sexual harm through mother's relationship with, and father's friendship/business relationship with sex offender 2 to the subsequent death of Mia from drowning after being left unattended by mother and father, has been debated by the LCSPR Panel. Both events were examples of the most serious forms of parental neglect (See paragraphs 5.12 and 5.13). Additionally, there appears to be very little room for doubt that in this household, life did not revolve arounds the needs of the children. In this household the needs of the adults were more important than those of the children and in this household the parents failed to protect their children, albeit from a range of different types of harm.

5.41 On the basis of this case, the whole system for safeguarding children from sexual harm has potential weaknesses which sex offenders may exploit. In particular the benefits of children's social care's MOSAIC system (See Paragraph 5.8), which would have allowed a search of Sex Offender 2's known association with other local children and families were not accessed at the time of the 25th

April 2020 incident. Had such a search been made it would have disclosed information children's social care held on woman A and her children who were known to be at risk from sex offender 2. Whilst it is much more challenging to track the risk of sexual harm sex offenders pose when they move across local authority boundaries, as sex offender 2 regularly did, it is essential that children's social care are able to respond to new risks of sexual harm to children that a sex offender presents in their own local authority area.

5.42 However, there was much effective information sharing between NPS, MOSOVO and Children's Social Care. Information sharing between NPS and MOSOVO appeared to be a constant 'back and forth'. NPS and MOSOVO promptly shared information about safeguarding concerns in respect of sex offender 2's relationships with woman A and her two children, woman B and her unborn child and possibly woman C and her child which enabled child protection planning to be initiated. However, it is unclear whether NPS advised Children's Social Care about sex offender 2's contact with father's brother's ex-partner when they first became aware of it.

5.43 To inform this review the Principal Social Worker has examined the reports provide by the police to ICPCs and found them to be of good quality and provide analysis of the accumulating risks sex offender 2 presented. The information from the police reports is copied into ICPC confidential minutes, enabling the allocated social worker, team manager and ICPC Chair to be well aware of risks and links to other families.

Recommendation 10

That CSAP obtain assurance that social workers, team managers and Child Protection Chairs ensure they escalate to their senior manager's that they have identified that a sexual offender is in contact with several families, in order that a review of all the families known to children's social care and other Local Authority children's social care services can be undertaken and referral made to MAPPA, if this has not previously been done by NPS or the police.

5.44 When NPS supervision of sex offender 2 ended on 26th February 2020 that appears to have been quite an important loss of regular contact/oversight of him. MOSOVO continued to manage him but the NPS had been very effective at obtaining disclosures from sex offender 2 and following up on information. However, MOSOVO has not submitted a separate chronology to this CSPR and so their actions are visible primarily in the NPS chronology entries.

5.45 At the time of the 25th April 2020 incident, in which the police, children's social care and MOSOVO became aware of the allegation from father that mother was in a relationship with sex offender 2 – which he then withdrew - Children's Social Care had just ended their involvement with woman A and her children as her relationship with sex offender 2 appeared to end in January 2020 and the case was transferred to another local authority within the region on 6th April 2020. It was another neighbouring Children's Social care, rather than that working with Mia and her family, who were working with woman B and her new born child. There seemed to be a delay in taking action in respect of woman C and her child with the ICPC not taking place until September 2020. Children's Social Care's involvement with father's brother's ex-partner in January 2020 appears to have been informal.

5.46 The NPS may have made the assumption that information shared with either local authority's children's social care would have been shared by each children's social care with the other but this doesn't appear to have been the case.

5.47 Both father and his brother's ex-partner are scout leaders. Father was referred to the Local Authority Designated Officer (LADO) in July 2020 but this was because he was offered employment as independent security at a hospital, an offer which was later withdrawn or put on hold. His role as a scout leader was considered as part of this LADO referral. It is not known if father's brother's ex-partner was referred to LADO or if the fact that sex offender 2 had befriended two scout leaders was regarded as significant.

5.48 MOSOVO has contributed to this review and noted that they were not made aware of the contact between mother, father and sex offender 2 following his arrest and remand. Mother and father were listed as telephone contacts for sex offender 2 by his prison and sex offender 2 maintained contact with mother by telephone and letter. Neither the prison service (via the VISOR information system) or children's social care shared this information with MOSOVO, although children's social care would have been entitled to assume that Lancashire Constabulary would ensure that relevant information from the child protection process was shared with MOSOVO.

5.49 This case opens a window onto the complex web of relationships a prolific, non-compliant registered sex offender can create with women, many of who have vulnerabilities, in order to sexually abuse their children.

Recommendation 11

That CSAP seeks assurance that there is a sufficiently robust process for information sharing between all relevant partner agencies when sex offenders are suspected of presenting a risk of sexual harm to children. In particular, information held by the National Probation Service and the Police MOSOVO should be included in the information sharing process.

5.50 This CSPR has been advised that training has been commissioned to be delivered by a recognised child sex abuse expert and author to all Children Services Team Managers including Early Help, Social Care and Adolescent Services and Youth Offending Team. This CSPR has also been advised that the NPS also plan to access this training.

5.51 Turning to point 4 (e), during the summer of 2017 registered sex offender 1 targeted a number of local families in order to have unsupervised contact with children. This review has been advised that sex offender 1 was assessed as 'high risk'. He groomed mother and, through this relationship had overnight contact with Adam. He also took Adam swimming which was sex offender 1's modus operandi for grooming and abusing children. There is no indication that Adam was sexually abused. It is not known whether children from other families targeted by sex offender 1 at that time were sexually abused.

5.52 Children's social care completed a CAFA and a CiN plan was implemented in an effort to protect Adam from the risk of sexual harm. After three months the CiN plan was closed after mother had demonstrated the ability to protect her son. She ceased all contact with sex offender 1, signed a schedule of expectations and was considered to have engaged with the CiN plan.

5.53 The school nurse supported Adam through the NSPCC 'Talk PANTS' programme which is designed to help children understand that their body belongs to them, and that they should tell someone they trust if anything makes them feel upset or worried. Adam was 7 years old at that time and transferred school from infants to junior over the summer in which he was exposed to risk from sex offender 1. It is understood that the majority of work was done by his infants school. It is not known how fully the concerns about his exposure to sex offender 1 were communicated to his junior school.

5.54 A potential area of learning from this review relates to the extent to which parents remain vulnerable to grooming by sex offenders even after professionals have formally worked with them to raise their awareness to the risks. In mother's case she began a relationship with sex offender 2 less than three years after she was groomed by sex offender 1 and her son Adam was exposed to the risk of sexual harm. By the time she began the relationship with sex offender 2, her life circumstances had changed markedly. She was the mother of Emma, Mia and Adam and also supported father in parenting Conner when he was staying with them. Given the earlier intervention following her relationship with sex offender 1, one would have expected her to have had a fairly high level of awareness that she could be exposing the four children to risk from sex offender 1. However, she was vulnerable at the time she met sex offender 2 in that she had given birth to Emma and Mia in fairly quick succession and as well as parenting these young children she was holding down a job in a nursing home where she worked regular night shifts which is likely to have resulted in tiredness during the daytime. She had experienced low mood and her relationship with father, who demonstrated coercive and controlling behaviours in his relationships with intimate partners and his children, had deteriorated. One assumes sex offender 2 would be well practised in picking up on, and exploiting mother's vulnerabilities.

5.55 However, the possibility that mother - and father - may have colluded with sex offender 2 cannot be ruled out as both mother and father were recorded by the prison in which he was held on remand following his arrest in June 2020 as telephone contacts for him, and sex offender 2 wrote a letter to mother dated 13th July 2020 (contents of letter not known) and she sent him a naked image of Emma from her phone at some point. Lancashire Constabulary's Management of Sexual Offenders and Violent Offenders (MOSOVO) team has contributed to this review and made the anecdotal observation that, in their experience, it was rare for a woman to be groomed by more than one sex offender.

5.56 There could be value in reflecting on how professionals could work more effectively with parents like mother whose relationship with a sex offender exposed her children to the risk of sexual harm. By the time sex offender 2 entered her circle of family and friends, mother's situation had changed quite significantly from the period in which she had been involved with sex offender 1. Perhaps more work needs to be done with parents like mother to explore their vulnerabilities and

build their future resilience, perhaps exploring how they could keep themselves and their children safe in future scenarios in which they may have increased vulnerability.

5.57 Whilst no criticism is made of the work completed with mother when she was exploited by sex offender 1 in 2017, by 2020 mother's life circumstances had changed markedly. In her contribution to this review, mother was critical of the work completed with her in 2017, although she may have taken this view in an attempt to excuse her subsequent relationship with sex offender 2. However, she accepted that she could have exercised more care in allowing sex offender 2 to have contact with her family.

Recommendation 12

That CSAP seek assurance that work to support women who have been exploited by sex offenders should consider a range of scenarios in which the woman might become vulnerable to exploitation in the future.

5. Did the restrictions imposed as a result of the Covid-19 pandemic have any effect on the single or multi-agency response to this case?

5.51 The Covid-19 restrictions introduced from March 2020 have had a significant impact on the provision of in-person health and social care services. The impact on this case appeared to be health visitor contact being made by telephone and reduced likelihood that professionals would enter the family home (the police noted mother and father's home to be messy by looking through the window when called to the 25th April 2020 incident). Covid-19 did not adversely affect the CAFA which was in progress at the time of the incident which led to Mia's death as direct work was done with Connor to hear his voice, wishes and feelings during nine home visits.

5.52 Sex offender 2's relationship with mother and the exposure of her children to the risk of sexual harm occurred just as the Covid-19 restrictions were being imposed. Researchers at the University of Birmingham are currently investigating how sex offenders have changed their behaviour in response to the Covid-19 outbreak noting that sex offenders are versatile and will change their behaviour according to circumstance and opportunity (4).

Good Practice

5.53 The overall management of sex offender 2 by NPS and MOSOVO showed good joint working and all known relationships were reported to relevant area children's social care teams.

5.54 As stated, once Connor's referral was forwarded to Children's Psychological Services in May 2019, he was seen for initial assessment in July 2019. At this appointment attended by father, mother 2 and Connor, concerns about father's controlling behaviour resulted in the decision to arrange for Connor to be seen at future appointments with just one parent attending alternate sessions.

5.55 The injury to Connor's foot by the 'recklessly thrown' cigarette (Paragraph 3.7) was notified to children's social care by referral from the child's GP. The review has been advised that this GP referral was very thoroughly completed.

5.56 Children's social care recommended a delay in Connor's overnight stays with father until the child was receiving support from the Children's Psychological Service (Paragraph 5.28).

6.0 List of Recommendations

Recommendation 1

That CSAP reminds professionals of the importance of documenting how a child is presenting and the interaction between the child and parent/carer in order to better understand the child's lived experience.

Recommendation 2

That when CSAP disseminates the learning from this case, the opportunity is taken to emphasise the importance of understanding the lived experience of children in blended families, particularly when they are visiting or staying in different households within the blended family.

Recommendation 3

That CSAP request all partner agencies to review their information systems in order to consider what changes may be necessary to facilitate professional focus on children in blended families who may move between households or may be affected by events which take place in a household in which they do not normally reside.

Recommendation 4

That CSAP ensures that 'situational risks' such as house moves and temporary housing are highlighted in the local response to the learning about sudden unexpected deaths in infancy highlighted by the National Child Safeguarding Practice review's report.

Recommendation 5

That CSAP seek assurance that the principles of 'Working Well with Children and Families in Lancashire' are consistently applied and that Early Help is offered where appropriate.

Recommendation 6

That CSAP seeks assurance over the steps being taken to reduce waiting times for Children's Psychological Services and also seeks assurance over the effectiveness of the monthly telephone/online contact provided to children and their families whilst on the waiting list.

Recommendation 7

That CSAP seeks assurance that GP's work with partner agencies to consider alternative approaches to supporting children who present with 'behavioural issues' before making a referral to CAMHS.

Recommendation 8

That CSAP considers the implications of a lack of a local Behavioural Support Service (and Learning Disability and Autism service – as reported on in previous CSPR for Ryan, Nathan and Amelia) and decides any action which may be necessary.

Recommendation 9

When the learning from this CSPR is disseminated CSAP take the opportunity to highlight the many, often subtle forms which coercive control can take in intimate and familial relationships.

Recommendation 10

That CSAP obtain assurance that social workers, team managers and Child Protection Chairs ensure they escalate to their senior manager's that they have identified that a sexual offender is in contact with several families, in order that a review of all the families known to children's social care and other Local Authority children's social care services can be undertaken and referral made to MAPPA, if this has not previously been done by NPS or the police.

Recommendation 11

That CSAP seeks assurance that there is a sufficiently robust process for information sharing between all relevant partner agencies when sex offender are suspected of presenting a risk of sexual harm to children. In particular, information held by the National Probation Service and the Police MOSOVO should be included in the information sharing process.

Recommendation 12

That CSAP seek assurance that work to support women who have been exploited by sex offenders should consider a range of scenarios in which the woman might become vulnerable to exploitation in the future.

Appendix A

Single Agency Actions:

Children's Social Care:

The Principal Social Worker has commissioned significant 8 days training for all Children Services Team Manager across Council Early Help Service, Children Social Care Service, Children with Complex Needs Service and the YOT Service.

LSCFT:

- Robust safeguarding supervision documentation to be embedded in practice through staff awareness of/implementation of LSCFT Safeguarding Supervision Best Practice Guidance.

- Routine Enquiry regarding Domestic Abuse to continue to be embedded into practice through online, virtual and face to face training.

- Awareness regarding 'blended families' will be embedded into practice via a 'Think Family' webinar/training available to all LSCFT staff. Webinar link:
- https://youtu.be/FaII2-jZ3v8

- Child Neglect half day workshop is available to all LSCFT staff to support understanding/clinical practice around Child Neglect issues and related risks.

- 'Learning on a page' in respect this and 1 other CSPR with themes around Neglect and Sexual Abuse will be disseminated to staff via safeguarding champions.

Education:

In order to foster further professional curiosity and improve general safeguarding practice in schools, this review has enabled us to have the following considerations:

- Include on the Admission forms of all schools and education settings the space for parents to cite additional significant adults, half-siblings and step-siblings to gain a better understanding of the extended family network.

- Include the same additional detail on the annual review of this key information that schools gather to keep their systems up to date.

- Improve the Safeguarding training of all staff in schools to understand the concept of professional curiosity and apply it to their daily practice as significant adults caring for children. This would enable Designated Safeguarding Leads to gather information about children's wider network and understand their lived experience better.

References:

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(2) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

(3) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

(4) Retrieved from https://www.birmingham.ac.uk/news/latest/2021/01/how-has-the-covid-19-pandemic-altered-sex-offender-behaviour.aspx