Child Safeguarding Practice Review

Overview Report: Child AB

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Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

Contents

1. Introduction

1.1 The siblings A and B, aged fifteen and six (as of May 2020) respectively, are the subjects of this child safeguarding practice review (CSPR-henceforth known as The Review). They are from East Lancashire and are of White British heritage with unspecified religion. Child A is the elder sister to her brother, Child B. Their parents are MAB (mother) and FAB (father).

1.2 In May 2020 they were removed from their mother's care by Lancashire Constabulary and placed in the care of the local authority. This followed information received by the Constabulary from another police force relating to an investigation concerning sexual offences against children involving an unrelated male who had been sent images of Child B by his father. FAB was at the time a convicted sexual offender having been found guilty of downloading indecent images of children in 2014. He was subject to a Sexual Harm Prevention Order (SHPO) and was being monitored by Lancashire Constabulary's Management of Sexual and Violent Offenders' team (henceforth referred as the MOSOVO). He was also subject to a three year community order consisting of a three year supervision requirement to the National Probation Service (NPS) with inclusion on an internet sex offenders treatment programme (ISOTP). NPS oversight was from 25.08.15 to11.10.18 and assessed him as being a medium risk.

1.3 FAB was supposed to be living apart from his family with contact to the children supervised outside of the home by MAB. Lancashire Constabulary attended the family home in May 2020 and saw the children as part of their investigation into the indecent images of Child B. In addition to sexual abuse matters, the Police were also concerned about the very poor state of the house which, according to photographic evidence, was uninhabitable. Both adults were arrested and charged with, in the case of FAB, sexual offences against children and breach of his SHPO; and child neglect by MAB. Criminal proceedings have since been concluded with guilty outcomes for both adults. MAB received two community orders with a rehabilitation requirement. FAB was sentenced to a custodial order in the summer of 2021.

1.4 Following their removal the children were made the subjects of interim care orders in mid May 2020 and placed in foster care where they remain following the conclusion of care proceedings in 2021.

1.5 Consequent to a rapid review in June 2020 by the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (henceforth referred to as the CSAP), a decision was made on the 26.06.20 to proceed to a child safeguarding practice review. An independent reviewer and chair were appointed in late 2020 (the delay was due to the restrictions resulting from the covid19 pandemic) and the first panel meeting took place on the 20.01.21.

2. Terms of Reference and Key Lines of Enquiry

2.1 See Appendix 1

3. Methodology, CSPR Process and Scope

3.1 See Appendix 2

4. Background and Significant Events

4.1 The children were made the subjects of Child in Need (CIN) plans between October 2014 and March 2015 due to concerns of sexual abuse arising from their father's downloading of indecent images of children and subsequent conviction in August 2015. For this, he was placed on the sexual offender's register, subject to a Sexual Harm Prevention Order and allocated a MOSOVO officer, in addition to probation intervention. An initial child protection conference (ICPC) was not thought necessary on the basis that the parents had separated and that the mother was considered capable of safeguarding the children. A CIN plan was deemed appropriate with contact between the children and their father supervised by the maternal grandmother.

4.2 Child A, on her mother's initiative became electively home educated (EHE) between January to July 2016. Her previous (primary) school voiced concerns in January to the Lancashire elective home education team that she had been withdrawn to care for Child B, then a baby. Home visits were done by EHE staff in April and June. Child B had his two year developmental assessment completed by the health visiting service (community nursery nurse) in May 2016. Concerns were noted regarding poor home conditions, lack of family support, the quality of education afforded to Child A and the children having contact with their father who was supporting the mother with their care. There were no records to indicate that these concerns had been passed on to the named health visitor as intended.

4.3 An initial child protection conference (ICPC) was held on the 18.07.16 following the Police discovery that MAB was sending images of her breastfeeding Child B to FAB, in addition to poor home conditions and the mother supervising contact between the children and their father. The children were made the subjects of child protection plans under the categories of sexual abuse and neglect. Child A, as part of the plan, began attending a local secondary school (X) in September and was closed to the EHE team.

4.4 The children's child protection plans finished on the 06.04.17, following a review child protection conference (RCPC) which decided to ' step down' to a level 2 Team around the Family (TAF) plan. A local children's centre was designated as the lead agency for the TAF, the main objective being the monitoring of home conditions for a short period. MAB was assessed as being able to protect the children from the risk of sexual abuse from their father. Agreement was reached for her to supervise contact between the children and their father , albeit in the community and not at home. On the 27.04.17, the TAF plan was finished (formally closed on the 10.05.17) , it being deemed that all of the actions were met. Lancashire Children's Social Care (CSC) closed the case on the 31.05.17. Following this date there was no statutory agency involvement with the children until the 12.05.20 (some three years) when the Lancashire constabulary intervened in respect of FAB's possession of indecent images of his son.

4.5 The closures of the child protection and TAF plans in April/May 2017 were followed in September by Child A not returning to school for the new academic year. Her mother had decided to opt once again for elective home education, thus triggering EHE team involvement again. Both children had intermittent involvement with GP and hospital services in the three years up to May 2020. Child B for speech and language issues, frequent stool passage and Child

A for several matters, including viral infection, headaches, knee pain, squint, asthma and anxiety/panic attacks. Both parents also had involvement with their respective GP practices. Child A was referred by her GP to the Children's Psychological Service on the 24.09.19 for anxiety and panic attacks. She received three sessions of brief self help intervention (known as '123 relax') between November 2019 to January 2020.

4.6 The health visiting service had intermittent involvement with Child B and his mother during the three years; mainly regarding the child's speech and language, a hospital admission follow up in October 2017, reported aspects of his behaviour and night terrors. A letter from the school nursing service was sent to Child A in August 2017 but face to face contact did not take place.

4.7 The EHE service visited the family twice in November 2017 regarding Child A's home education following her mother's request in early September. There are no records of any further visits after this time.

4.8 FAB received regular monitoring visits from his offender manager (MOSOVO-Lancashire Constabulary) as part of the conditions of his SHPO between June 2017 to May 2020. FAB had telephone contact on the 13.12.19 , via his GP practice, with a mental health practitioner from the speialist triage assessment, referral and treatment team (START). This was for reported symptoms of depression, anxiety and suicidal thoughts, including strong urges of accessing child pornography on the internet. He had not been taking his medication for the previous eighteen months. The Police MOSOVO reported having had contact with the START practitioner on the 13.12.19, regarding the concerns about FAB's welfare. His phone was examined but no evidence was found of any attempts to access indecent images of children. There was no evidence of either the GP/mental health practitioner or the MOSOVO contacting children's services regarding any consideration of their safety and wellbeing.

4.9 FAB was also subject to a three year community order consisting of a three year supervision requirement to the National Probation Service (NPS) with inclusion on an internet sex offenders treatment programme (ISOTP). NPS oversight was from 12.10. 15 to11.10.18 who assessed him as being a medium risk.

4.10 FAB was telephoned assessed on the 14.04.20 by a START practitioner some four months after his crisis assessment in December 2019. He did not think that any further intervention was needed as he reported an improvement in his emotional state since December having resumed his medication and having had a review by his GP. There was no further involvement from the START.

4.11 The Police investigation of the 12.05.20 (see above) triggered the series of events which resulted in the children becoming looked after by the local authority and care proceedings starting on the 15.05.20. The parents were charged with several criminal offences and subsequently convicted in December 2020 and 2021 respectively.

5. Analysis of Practice Against the Key Lines of Enquiry (KLOE)

5.1 The Child Protection Plan

5.1.1 The children were the subjects of child protection plans from July 2016 to April 2017 under the categories of sexual abuse (primary) and neglect (secondary) respectively. The main concerns were in respect of the risks presented to them from their father's conviction in 2015 for downloading indecent images of children, his self confessed sexual predilection for pre-pubescent children, their mother sending him inappropriate photos of her breast feeding child B, serious questions about her ability to protect them and concerns around not meeting the children's basic educational, social and developmental needs. Neither parent agreed with the concerns and had little insight or understanding of the identified risks to their children. They disagreed with the children being on child protection plans.

5.1.2 A core group was appointed at the initial child protection conference (ICPC) consisting of the social worker, health visitor, school nurse, home education support worker and the parents. The Police and probation service would liaise with the core group through the social worker and provide timely review reports on FAB's progress and risk. Arguably, both of these agencies should have been included in the core group, given that FAB's risk and its management were key issues in the case. Subsequent core groups included a family support worker from a children's centre. Whilst not present at the ICPC due to Child A being home educated and therefore not on the school roll, school X became part of the core group and was included in the two RCPCs, following Child A's start there in September 2016.

5.1.3 Regarding the overall effectiveness of implementation of the child protection plans the evidence suggests that this was mixed. Timely statutory social work visits were undertaken, core groups met frequently and review child protection conferences were held on time. The children were benefiting from attendance at a local secondary school (child A) and a creche (child B) respectively. FAB had complied with his probation supervision requirement and completed the internet sex offenders' treatment programme (i-SOTP). There was no evidence that the children had suffered sexual harm or significant neglect during the period of the child protection plan. Their health and development were noted by professionals to be positive. MAB's emotional and mental health state had improved, as had her general care of the children.

5.1.4 However, there were few unannounced visits as per the plan, partly because of obstruction by MAB and child A was rarely seen on her own to ascertain her views. There was a lack of consistent attendance by core group members which undermined the effectiveness of the child protection plan.[1] Moreover, of some concern, there were no reports from the GP practice which was not aware that the

[1] There was no attendance by the health visitor and school nurse at three core groups between December 2016 and February 2017, a crucial time in the child protection plans. It was possible that there was a change of staff and staff sickness.

children were on child protection plans. The police and probation service should have been included in the core group and present at the final RCPC in April 2017 (albeit they provided reports) to participate in the discussion around risk assessment and management of FAB after the ending of the child protection plans.

5.1.5 In relation to reviewing the plans, core groups and RCPCs were held within prescribed timescales. However, as mentioned above, the inconsistent and intermittent attendance of core group professionals and changes in group membership arguably diluted the group's collective knowledge of the case and appreciation of the risks to the children. The change of IRO would have compounded this process with the statutory reviews. IRO1 who chaired the ICPC and first RCPC in October 2016 reportedly completed one, 'mid point', check, but their notes did not include an oversight analysis of progress with the plans.

5.1.6 The practitioners' learning event was informed by the CSC representative that current practice would now include the IRO having a greater oversight of the child protection plan, including documenting on the, ' IRO monitoring between reviews' case notes.[2]

5.1.7 The final RCPC at which the decision was made to end the child protection plans was chaired by a different IRO (IRO2). It was attended by the social worker (SW2), the allocated school nurse and health visitor and a children's centre worker, identified as a Sure Start representative in the meeting attendee's record. The probation representative gave apologies for absence but had provided a report. There was also a school nurse report. There were no representatives from the Police, child A's school or anyone from the elective home education service (possibly because child A was attending school), or either GP practice. The parents also attended.

5.1.8 The RCPC considered evidence from the reports of the social worker, school nurse and FAB's probation officer. IRO2's summary cited that FAB had engaged well with his community order and had completed his sex offenders' programme with the probation service. However he had admitted to having a sexual predilection for pre-pubescent females (6-10 years) and was assessed as being a medium risk to children. SW2's children and family assessment was generally positive about the progress made by the children and their mother. Work with child A around ' keeping safe' and wishes and feelings had gone well and she was wanting more contact with her father. Child B had attended a creche which had been beneficial to his development.

[2] The IRO service in April 2016 was significantly understaffed and operated on 51% of agency workers with an average caseload of 92 per IRO, a figure in excess of recommended caseloads at the time (see IRO handbook). 2017 saw an increase in IRO recruitment to the service (local authority) with a decrease to 75 cases per IRO by March 2017, allowing for greater case oversight as per the IRO handbook. Moreover, there were significant increases in both children looked after (7.9%) and those on child protection plans (936 in March 2015 to 1460 in March 2016, a 60% increase) in 2016 which added to the demands on CSC social workers and IROs. The increased pressures on both social workers and IROs led to low staff morale and high turnover of personnel. In January 2021 the IRO service had no posts covered by agency workers and had an average caseload of 62.6. IROs now have a reduced caseload compared to 2016, thus allowing for completion of the, 'Monitoring between reviews', case notes. This contains a more detail analysis of the child protection plan.

5.1.9 9 Moreover, on the understanding that FAB was permanently living away from the family it was deemed appropriate for MAB to supervise contact between the children and their father in the community, away from the family home. This was to be underpinned by a contact agreement and a team around the family (TAF) plan led by the children's centre to monitor remaining concerns about home conditions. In the event that the parents resumed their relationship or FAB started another one, CSC should be alerted and consideration would be given to any potential safeguarding concerns.

5.1.10 It would seem then, that the rationale for the ending of the child protection plans and the decision to allow contact to be supervised by MAB in the community was based upon the positive reports from the agencies. However, as was identified by the CSC agency report for this review and the practitioners' event, the assessment of MAB's ability to safely supervise the contact in the long term would have benefited from a more specialised risk assessment from an external agency. Unfortunately, this was not available to CSC at the time, albeit is now.

5.1.11 Arguably, the CSC assessment of MAB could have been enhanced by discussion with the probation service and the MOSOVO team regarding its up to date assessments of any risks presented by FAB to his children. The OAsys[3] probation assessment completed on the 28.10.15 concluded that FAB was a ' medium risk'[4] to children. A more integrated risk assessment informed by CSC, probation and MOSOVO would, in all probability have resulted in the same risk category, namely medium risk. However, it could have provided some relevant and robust multi-agency risk management strategies in regard to the post child protection plan period, particularly in relation to the issue of MAB's supervision of contact between her children and their father.

5.1.12 Thus, for example, there could have been a coordinated risk management approach to the children's wellbeing and safety involving child A's school, the family GP, the police and probation services. In the event of any significant change in the children's circumstances, for example, the parents resuming their relationship and FAB having unsupervised contact or contact at home, or FAB entering into another relationship, this could have triggered an alert to CSC who could have considered whether to initiate any appropriate safeguarding action.

5.1.13 On balance, the decision to end the child protection plans was probably appropriate in all of the then known circumstances, given the information and knowledge of the family available to the RCPC at the time. The children could not have remained on their child protections plans indefinitely and there were insufficient grounds for local authority intervention via care proceedings. This gave the local authority a dilemma. On the one hand the child protection plans had provided the children with some protection and safeguarding. Conversely, the end of the plans handed the management of risk to MAB which was based upon

[3] Offender Assessment system.

[4] Defined as, 'identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse'. (National Offender Management Service, Public Protection Manual, 2016, page 2)

the agencies having confidence and trust in her willingness and ability in the long term, to protect her children and sustain the provision of good enough parenting and care.

5.1.14 In conclusion, this turned out not to be the case. The assessment of MAB's capacity to protect her children underestimated the risk from their father, in addition to considerations of future neglect. As acknowledged by CSC, the use of a more specialised risk assessment service looking in more depth at FAB's risk could have perhaps led to a more structured risk management arrangement involving the police, probation and school X. Arguably, they could have remained on plans for a further six months to embed, test out and monitor improvements and facilitate the continuation of child A's schooling. Alternatively, the child protection plan could have been, ' stepped down', to a child in need (CIN) plan to achieve the above. In the event, a recommendation was made at the RCPC to place the children on a level 2 short term Team around the Family plan.

5.2 The TAF plan

5.2.1 It was not recorded in the RCPC minutes, nor the final core group or CSC child and family assessment, what the rationale was for a TAF plan, or indeed, why there was no consideration for a child in need plan. The lead agency was the children and family wellbeing service (CFW) using a children's centre family support worker. The CSC agency report for this review noted that the rationale for a step down to a CIN or TAF plan, following the ending of a child protection plan, should have been set out in the CSC child and family assessment and RCPC minutes. That said, the RCPC minutes noted that work had been completed with MAB concerning her understanding of abuse and the risk presented to her children by FAB. The expectation was that she was being trusted to manage these over the long run and that further testing out of her ability to do this was not part of the TAF plan.

5.2.2 In any event, it would seem that the only objectives of the TAF plan were for the children's centre worker to monitor home cleanliness and for MAB to complete a maths and English course. There were no explicit safeguarding considerations. Unfortunately neither the children's centre manager or the family support worker are currently employed by the CFW so it was not possible to tease out and understand fully the reasons and rationale for the three week TAF plan. The family support worker made one home visit and reported to the TAF review meeting held in late April 2017 that home conditions were adequate. Moreover, MAB had apparently completed her maths and English courses. Those attending the TAF review (family support worker, social worker and health visitor) deemed that the family's needs and TAF objectives had been met thus justifying case closure. It was deemed that any future needs could be met at a universal level; presumably through primary health and child A's school.

5.2.3 This review would question the efficacy of the TAF's short term focus on home conditions and the completion of MAB's educational goals. Employing a cleaner would not seem to be reasonable test of MAB's ability to sustain acceptable conditions over the longer term for her children, notwithstanding any safeguarding considerations. This review would argue that any step down plan (CIN or a TAF) should have supported MAB and the children in embedding the

positive changes; including encouraging attendance at nursery and school for the children, over a longer time horizon, say six months. In short, three weeks for the TAF would seem not to have been long enough to test out the sustainability of change made by the family during the child protection plan. There was no evidence of any CSC or CFW management oversight or approval regarding case closure. The involvement of child A's school in the TAF would have been beneficial.

Current_Practice

5.2.4 TAFs are now reviewed online by a senior family support worker and cases cannot be ended without management oversight and a documented rationale for closure. CFW is now part of the Children's Services, ' Liquid Logic', case management system that includes access to CSC historical information on children and families, as well as child protection and CIN plan records. CFW state that it now has robust step down procedures that involve a social worker handover (there was not one in children A and B's case) to the family support worker in complex cases. Step down from CSC are now managed by a family intensive support team. There are escalation processes to provide for challenging whether cases meet the threshold for support or when there is a need to step up to CSC child protection statutory intervention.

5.2.5 Moreover, CSC and Early Help (as CFW is now called) now have a service manager to ensure that transactions across the two services are consistent; that common thresholds are applied and services are aligned to ensure that children and families are effectively supported across the services. The service manager implements a robust, 'step down', procedure to ensure that when children and families step down from child protection the new plan addresses all areas of remaining risk and need. In addition, training around threshold guidance and transforming children's services has also been developed for internal professionals and external partners to ensure a smooth transition between CSC, Early Help support and Universal services.

5.3 Effectiveness of Universal Health Services

5.3.1 Universal health services involved with the children and their parents included health visiting, school nursing, and the separate GP practices of mother and children and the father. The first two services were provided by Trust 1 up until April 2019 when they were transferred to Trust 2.

5.3.2 Health Visiting and School Nursing: There had been several previous health visiting episodes with the family following child A's birth in 2005 (Universal core programme until 2009), child B's birth in 2014 (initially Universal and from October 2014, targeted health visiting and school nurse intervention during the CIN plan) prior to the child protection plans of 2016/17. As mentioned above the 2016/17 period involved targeted support from the two services.

5.3.3 For some unknown reason (not evident in the records) there was a change of health visitor for child B in July 2016 (the start of the child protection plan) from HV1 to HV2 and then back to HV1 in September of the same year. Involvement of

the two services in the child protection plans has previously been examined above, albeit it is of some significance that there was no involvement by either of these two services between December 2016 to February 2017 when three core groups were missed (see note 1 above).

5.3.4 Post the child protection and TAF plans in April 2017 the health visiting service provided some support and advice (telephone and post) to MAB regarding child B's drooling, behaviour and sleep management (October 2017)[5]. There was no recorded follow up by the school nursing service regarding an outstanding action from the final RCPC to see child A in school about her mother's concerns that she had no one to talk to in school. However, it would appear that because the contact had lapsed with the school nurse a letter was sent in August 2017 to child A offering her support if she needed it, along with information on the CHAT (an 11-18 years safe chat service with the school nurse service) health service. Child A was weighted to universal services by the school nursing service, despite having been no follow up with Child A in compliance with the final RCPC. This appears to have been a missed opportunity for child A to have voiced her wishes and feelings about school and any other issues.

5.3.5 In October 2017, MAB was admitted to a local hospital for five days. The health visitor became aware that child B had been brought to hospital with vomiting and a high temperature by his father during that time. Child B had been discharged home to his father by the hospital staff which raised concerns about the latter's contact with his children. Subsequently, MAB told the health visitor that her mother (maternal grandmother) had taken child B to the hospital , along with FAB. There was no evidence that the health visitor liaised with the hospital to establish the facts or challenged the parents on whether FAB had sole care of the children or if arrangements had been made for the maternal grandmother to do this.

5.3.6 During the above episode, MAB had asked for health visiting support with child B's behaviour and sleeping management. It was agreed that a home visit would be made a few weeks later once MAB had recovered from her illness. In mid November 2017 a planned visit was cancelled by MAB who was reportedly unwell. Information was posted to MAB and a new visit was arranged for the end of November. Rather than visit, the health visitor spoke with MAB by phone who reported that child B's behaviour had improved slightly but he was having, ' night terrors'. MAB had requested her GP to refer child B to a paediatrician but was apparently told that he was too young. The health visitor gave advice over the phone, posted more literature and suggested MAB get a second GP opinion and agreed to follow up in a week's time.

5.3.7 A follow up by phone took place in early December 2017. MAB reported that child B was continuing to have nightmares and put this down to him being insecure since her recent hospitalisation. She was offered further support but declined and weighted to universal services. A home visit in this instance to assess child B's behaviour and night terrors would have been expected practice, given his

[5] MAB cancelled a home visit by the health visitor in October 2017 due to ill health, resulting in tele-phone and postal follow up.

safeguarding history and context of only recently having been subject to a child protection plan and the concerns about his father. This episode seemed to lack sufficient child focus and was more concerned with responding to MAB.

5.3.8 Thereafter, there was no active involvement with the family from December 2017 to May 2020. The children's health needs were assessed as requiring a Universal core programme following the ending of the child protection plans in April 2017. There were no further requests from other agencies or the family for school nurse intervention, which was not surprising given that neither child was in school or on the roll.

5.3.9 In December 2018 child B was a ' rising five' and eligible to start school. The school nursing service recognised that they had no information about his school attendance and sent a letter to his mother asking her to complete and return a form indicating which school he would be starting. There was no record of MAB providing the information nor any follow up by the service. In the light of prior multi-agency involvement good practice should have involved follow up action, including a visit to see child B, to ascertain his school attendance. In the event, he was never on a school roll whilst in his mother's care.

5.3.10 Finally, there was no recorded evidence that any of the health practitioners received supervision despite the children being subject to child protection plans.[6]

5.3.11 In conclusion the episodes cited above suggest that health visiting and school nursing services (whilst part of Trust 1) fell short of expected safeguarding practice regarding a lack of child focus, professional curiosity and failure to follow up on the needs of the children. There were several missed opportunities to have seen the children, assessed their needs, safety, wishes and feelings. On this basis it can be concluded that intervention by the two services was suboptimal in safeguarding and promoting the children's welfare and wellbeing.

5.3.12 The review was unable to view Trust 1's records; the agency report was provided by Trust 2.[7] Thus it was not possible to understand Trust 1's organisational context and operating environment within which the suboptimal practice, actions and decisions were made by health visiting and school nurse practitioners. There may have been several barriers to expected practice such as understaffing, poor management oversight and organisational change accounting for the deficits cited above. Trust 2 has identified the relevant learning and required improvements from this practice review and implemented an action plan to ensure that current health visiting and school nurse provision is consistent with expected safeguarding policy and practice.

<u>GP Practices</u>

[6] It should be noted that prior to September 2016 staff supervision involved a reflective look at one or two child protection cases every 4-6 weeks. The focus was on practitioner reflection/ development rather than on an individual child or case. Hence, not all cases were discussed which would account for the absence of any recorded discussion regarding the children A and B. Since 2017 there has been a change in supervision policy towards a recorded consideration within six months of every child on a child protection or child in need plan.

[7] Trust 2 provided all of the information regarding health visiting and school nursing contacts with the family, from Trust 1 and Trust 2. All records and staff transferred from Trust 1 to Trust 2 in April 2019.

5.3.13 The GP practices (GP1 for the children and MAB; GP2 for FAB): The evidence examined by this review indicates that the two GP practices fell very short of contributing to the effective safeguarding and promoting the children's welfare. There were several instances of this as set out below.

5.3.14 Firstly, for reasons unknown GP1 was unaware that the children had been subject to child protection and TAF plans in 2016/17. There were no GP records of the children's plans, nor minutes of meetings, despite the child protection outcome plan having been sent within 24 hours to GP1's practice. Moreover, although having been sent an invitation to attend the ICPC or at least provide a report, none was forthcoming.

5.3.15 Secondly, child A had been seen by GP1 in June 2016 (aged eleven) for low mood and thoughts of self-harm. Her school performance had deteriorated and she was being home educated. There was no recording of any discussion with her of the reasons for her low mood and self harming thoughts, albeit a referral was made to child psychology at ELCAS (East Lancashire Child and Adolescent Service). This episode was not mentioned at the ICPC because it had not received a GP report. In the event, the school nurse picked it up in the course of completing an individual health assessment (IHA) on child A as part of the child protection plan. Unfortunately, MAB did not make an appointment with the service and child A's low mood and thoughts of self harm were not assessed and addressed, this being at a time when she was on a child protection plan. Neither the school nurse nor the GP followed up child A's ' no show' with ELCAS.

5.3.16 Thirdly, on the 13.12.19 FAB attended GP2 and reported symptoms of depression, anxiety and suicidal thoughts, including strong urges of accessing child pornography on the internet. He had not been taking his medication for the previous eighteen months. He informed GP2 that he had supervised contact with his children due to accessing child pornography five years previously. GP2 made a referral to the mental health team but did not think to inform Children's Social Care or the Police given the obvious safeguarding implications of FAB's consultation.

5.3.17 In the event, FAB was phoned triaged at the GP surgery the same day by a START[8] mental health practitioner who did inform the police MOSOVO team of his urges to access indecent images of children. However, an assumption was made that the Police would share the information with CSC which did not actually happen; resulting in no safeguarding referral from START to CSC as per procedures. There was a four month delay before FAB was telephone assessed in April 2020 by the START team. He felt well and it was agreed that no further mental health input was needed. There was no record of any discussion around accessing indecent images of children or contact with his own children. (See later section re MOSOVO/ Probation and START).

5.3.18 The above episodes (of 2016/17 for GP1 and 2019 for GP2) are concerning and suggest a lack of safeguarding awareness, effective information sharing/recording systems and professional curiosity, tantamount to a significant

[8] Specialist Triage Assessment and Referral Team (START)

disconnect/systemic failure between the two GP practices and the local multi-agency safeguarding network.

5.3.19 This review was informed by the panel CCG representative that the two GP practices in question have a generic e-mail which should be used to send information. When there is a request regarding an ICPC the CSC sends it to the CCG safeguarding team who check that the practice details are correct and then forward the request to the practice's generic e mail and also the practice safeguarding lead.

5.3.20 The review learnt from the practitioners' event that currently, all GP practices in Lancashire now have a designated doctor whose responsibilities include offering guidance and supervision regarding safeguarding issues. Moreover, the review was informed that all GP practices should have their own safeguarding policies and access to and should be following pan lancs procedures: https://panlancashirescb.proceduresonline.com/.

5.3.21 This review welcomes the above apparent system improvements.[9] However, notwithstanding this, the review would submit that GP practice shortcomings (albeit several years ago) were such that the local CCG needs to reassure the Safeguarding Assurance Partnership that significant improvements in safeguarding practice (including not only information sharing but also safeguarding awareness and professional curiosity) have been made with the two GP practices and if needs be the wider local GP network, such that they are now operating safely and in the interests of local children and young people.

5.4 Children's Psychological Services

5.4.1 A first referral regarding child A's anxiety symptoms and panic attacks was made in late March 2019 by GP1 practice to the East Lancashire Child and Adolescent Service/ELCAS. There was no record of any response. GP1 made another referral six months later in late September 2019 when it was agreed that the child psychology service (CPS) was best placed to respond to child A. An appointment letter for an initial assessment scheduled for the 27.11.19 was sent out on the 09.10.19.

5.4.2 Child A's initial assessment fell short of expected practice in that it omitted to consider safeguarding issues. MAB had mentioned the previous involvement of children's social care (CSC) and that the children's father had supervised contact with them because of his criminal record of sexual offences. Despite this knowledge no questions were asked about who was supervising the contact, nor was any contact made with CSC to establish the veracity of MAB's account.

5.4.3 Child A subsequently attended for three sessions of 123 relax (brief self help intervention) with a family support worker between December 2019 and January 2020. Part of the intervention involved the support worker and Child A completing a work book that sought to capture her lived experience.

[9] NB. See appendix 5 setting out the East Lancashire CCG GP safeguarding improvements and actions taken

5.4.4 Reason's given for not triangulating with CSC were that the information from MAB was, ' historical', and liaison therefore not needed. This review was informed that 95% of the children seen by the CPS have had historical or current involvement with CSC which begs the question of how often did CPS contact CSC regarding safeguarding issues during this time? This review was informed that contemporaneous safeguarding procedures were in place. However, consequent to this CSPR the LSCFT has produced a (enhanced) procedure (SG001) to ensure triangulation with CSC in the event of both current and ,' historical', involvement with the latter agency, where physical/sexual abuse and sexual offending are mentioned in the course of an initial assessment by the CPS.

5.4.5 During the course of the therapy the family support worker involved with child A contacted the CSC to enquire about support for the children during their mother's upcoming admission to hospital for an operation. Despite being told that a response would be made within 24 hours this was not forthcoming. It is not known why there was no CSC response nor why the family support worker did not follow up the request.

5.5 Hospital Safeguarding

5.5.1 The key practice episode here concerns the time that MAB was in hospital (H1) in October 2017. This coincided with child B's presentation at H1's emergency department (ED) along with his father, following a referral by GP1 practice for a high temperature and vomiting.

5.5.2 H1's General Admission Document (GAD) had noted that MAB was living with her children. There was no documentation regarding who was caring for them, albeit H1 does point out that it is the parent's responsibility to ensure that adequate childcare is sought for any children. The GAD has subsequently been updated to include a section on caring responsibilities encompassing children and vulnerable adults. The GAD now asks who the patient lives with and if there is/has been any social care involvement.

5.5.3 ED staff checked with the Child Protection Information System (CP-IS) and ascertained that child B had been subject to child protection plan that had finished in April 2017 and was no longer active. There was therefore no reason to interrogate the CP-IS given that the child protection plan had ended. ED completed a child risk assessment tool (CRAT) which did not identify any safeguarding concerns with child B's presentation, thus negating any justification to contact CSC. A paediatric liaison form was sent to the health visitor regarding the attendance in line with expected practice.

5.5.4 In March 2017, child B, whilst still on a child protection plan attended H1's ED for an arm injury (soft tissue injury; said to have fallen over some shoes). Information was shared with paediatric liaison as per policy. In the event, the health visitor was notified of Child B's hospital attendance which was passed onto the social worker and followed up by the health visitor.

5.5.5 In conclusion, the actions taken by ED staff at hospital H1 regarding the above episodes was compliant with expected agency safeguarding policy and practice of the time.

5.6 Elective Home Education (EHE)

5.6.1 Context: Current national policy and legalities - see appendix 3

Lancashire EHE Team Intervention

5.6.2 MAB's decision to withdraw child A from school X in September, some five months after the ending of the child protection triggered the involvement of the EHE team. This followed School X's notification to EHE on the 06.09.17 as per procedure. The notification stated that it was, ' unsure' , if there were any safeguarding concerns or whether child A had a statement of SEN (special educational needs).

5.6.3 There was no evidence that the EHE worker (the same one who had dealt with the family in 2016, who knew child A's history and the fact of a child protection plan) had contacted the school to clarify the situation around safeguarding, nor whether the school had contacted CSC to inform them, in the light of previous safeguarding concerns around sexual abuse and neglect, of child A's removal. There was no evidence that any action (under S.436 A of the Education Act 1996) was taken to ascertain the suitability of child A's education and whether, in compliance with section 175 of the Education Act 2002, there were any safeguarding issues.[10]

5.6.4 Assuming approval from MAB, a home visit should have been undertaken. In the event that her permission was not forthcoming consideration could have been given to pursuing a school attendance order or considering child A to have been a ' child missing from education'. Alternatively, it would have been reasonable, in all of the circumstances, for the EHE team to have made a referral to CSC for it to consider making enquiries under the Children Act 1989 regarding child A's (and B's) safety and wellbeing, given the recent ending of the child protection plans.

5.6.5 In the opinion of the lead reviewer, this omission amounted to a missed opportunity to have taken action to safeguard the children and promote their welfare.

5.6.6 Annual review letters were sent to the family in the years 17/18, 18/19 and 19/20 requesting updated details from MAB. No response was forthcoming yet despite this, there was no follow up action from the EHE team. CSC's electronic recording system ('Liquid Logic') was accessed by the EHE team annually to see if the children were on an open case but as it was closed, no further action was taken.

5.6.7 This Review would question why no follow up actions were taken as set out above, in compliance with DfE guidance.

5.6.8 Concerning Child B, his mother was under no legal obligation to notify the local authority that he was being home schooled. Because of this his name was never on a school roll and he was thus not known to the local authority EHE team or indeed any primary school. In short, he was not on the local authority, 'radar', from

[10] In addition, the local authority general duty under sections 10 and 11 of the Children Act 2004 to safeguard and promote the welfare of children in their area, including those in home education.

a schooling/education perspective. This was detrimental to him on both educational and safeguarding grounds as later events were to show.

5.6.9 Arguably, the legal loophole not requiring parents to notify the local authority of their rising five child's home education presents a significant gap in ensuring that the child is receiving an', efficient and suitable', [11] education and that any safeguarding needs[12] are being met. This review would respectfully suggest that the DfE needs to address this issue in a timely manner such that local authorities are aware of the education status of all rising five children.

5.6.10 Regarding Child A, there would seem to have been a degree of ' silo working' and a lack of professional curiosity shown by the EHE team, notwithstanding any possible organisational barriers within the operating environment impacting on practitioners, including a lack of suitable national and local guidance on safeguarding considerations in respect of home schooling. Moreover, as acknowledged at the practitioners' learning event, there was an absence of considerations and actions regarding the children's safeguarding and wellbeing. The EHE team should have challenged the suitability of home education ostensibly being offered to child A, which may also have resulted in any safeguarding concerns being referred to CSC. That said, it is acknowledged that the EHE team was operating without clear national and local guidance at the time.

5.6.11 In sum, the evidence suggests that the EHE team's practice was ineffective in both ensuring the suitability of child A's education and promoting their safety and wellbeing.

National Developments

5.6.12 The DfE is consulting on possible changes to the current non-statutory (2019) EHE guidance regarding local authority registration, greater monitoring and oversight and family support of children being home educated. The Children's Commissioner (February 2019) has called for,

- A mandatory home education register requiring parents to register their children with the local authority. This would include the child's name, date of birth and address at which they are being educated.
- A requirement for parents to inform the local authority if they move away from the area and re-register the child with the new local authority. Councils should develop information sharing agreements to further ensure that children do not disappear ' off-grid' after moving.
- Council education officers should visit each child being home educated at least once per term to assess the suitability of their education and welfare. This will require additional funding for local authorities. Where there are concerns regarding a child's welfare they should be spoken to without parents present.

[11] As per section 7 of the Education Act 1996, see appendix 3 below.

[12] As per the Children Act 1989 and other safeguarding legislation/guidance

- Advice and support: The local authority should visit the child and family within three days of a decision taken for the child's removal from school to be home educated. Advice and support should be provided by the local authority on alternative options, including other schools the child could attend. Information should be provided to parents so that they are aware of what they are taking on, including their responsibility to meet exam costs, and offer help negotiating entry to another school if desired.

5.6.13 The National Society for the Prevention of Cruelty to Children (NSPCC) is advocating for a register of all home educated children which would, ' help local authorities discharge their responsibilities assessing first and foremost the safety of the child, as well as the suitability of the education provided'.[13]

5.6.14 A recent report published by the House of Commons Education Committee has called for a national register of home educated children in England. Its chair (Robert Halfon, MP) stated that local authorities must," keep a much closer eye", on how home educated children were progressing.[14] However, greater local authority oversight of EHE was opposed by some parents' groups such as , ' Education Otherwise', arguing that there was no basis, or benefit to registration of home educated children. Such a move would tend to increase EHE families' lack of trust in public bodies even further.

5.6.15 There is no mention of EHE and safeguarding in the current (2018) version of ' Working Together' which is a major omission. Local authorities and their safeguarding partnerships should be provided with clear and robust guidance regarding the interface between EHE and safeguarding.[15] A flow chart integrating the charts at pages 41-43 in the current DfE ' Elective home eduction' (April 2019) guidance and safeguarding should be undertaken at the earliest opportunity. Guidance should include addressing the legal loophole regarding the need for parents to notify the local authority that a, 'rising five', child is being home educated.

5.6.16 The evidence from this review and the above national authorities (including the House of Commons Education Committee) provide (in the opinion of this review), compelling reasons for the adoption of mandatory local authority registration of all home schooled children. The lead reviewer would respectfully argue for the adoption by the DfE of all of the measures called for by the Children's Commissioner as set out in paragraph 5.6.12 above.

5.6.17 Lancashire Elective Home Education: Current Developments in italics. Set against the Children's Commissioner's recommendations at paragraph 5.6.12 above

[13] Written reply to the lead reviewer, March 2021.

[14] See the recent Government announcement, 'How we plan to support families who choose home education through registers children not in school' (3 February 2022). The intention is to set up a system of local authority administered registers for children not in school to enable local authorities to make sure they know where every child is being educated, that it is of the right quality, and that support is offered to home education families.

[15] Albeit there is a brief section on EHE and safeguarding in the current edition of Keeping Children Safe in Education (September 2021, page 42) and a section in EHE guidance (April 2019), 'Safeguarding: the interface with home education' at page 22.

5.6.18 A mandatory home education register requiring parents to register their children with the local authority. This would include the child's name, date of birth and address at which they are being educated.

5.6.19 Lancashire County Council (LCC) has a register of all children and young people removed from a school roll for the purpose of home education.

5.6.20 A requirement for parents to inform the local authority if they move away from the area and re-register the child with the new local authority. Councils should develop information sharing agreements to further ensure that children do not disappear ' off-grid' after moving.

5.6.21 All children and young people who move out of the Local Authority (LA) are tracked out through Children Missing From Education (CME) processes. The expectation is that any child coming into the LA is thus notified by the home LA that they have arrived in LCC.

5.6.22 Council education officers should visit each child being home educated at least once per term to assess the suitability of their education and welfare. This will require additional funding for local authorities. Where there are concerns regarding a child's welfare they should be spoken to without parents present.

5.6.23 Legislation does not allow LA's to intervene unless there are concerns that a suitable education is not being provided.[16] To be able to speak to a child without a parent present would require a s.47 enquiry to be initiated.

5.6.24 Advice and support: The local authority should visit the child and family within three days of a decision taken for the child's removal from school to be home educated. Advice and support should be provided by the local authority on alternative options, including other schools the child could attend. Information should be provided to parents so that they are aware of what they are taking on, including their responsibility to meet exam costs, and offer help negotiating entry to another school if desired.

5.6.25 The EHE support workers make telephone calls to all new parents when in receipt of EHE notifications. If there are concerns around the decision making of parent to EHE a Children's Champion is alerted and will pick up the case for the family.

5.6.26 Additionally, the council consulted (January 2021-May 2021) with partners and the EHE community and LCC guidance has now been updated and brought in line with 2019 DfE guidance. The government's revised, strengthened 2019 EHE guidance to LAs explains how a LA's safeguarding duties can be engaged in these circumstances, and what steps they can take. It sets out in clear terms the steps that the LA can take where it is not satisfied that the education provided by parents is suitable, including the point at which the LA's safeguarding powers become engaged.

5.6.27 LCC's existing powers, as set out in the government's guidance, are enough for LCC to determine whether provision is suitable. DfE's guidance for LAs does detail eight components (see paragraph 9.4) that LAs should consider when determining

[16] Or there are safeguarding concerns under the Children Act 1989 and 'Working Together' 2018 guidance.

whether a child is receiving a suitable education. This includes: isolation from a child's peers indicating possible unsuitability; enabling the child to participate fully in life in the UK; and, education not conflicting with Fundamental British Values, to name but a few. Unsuitable education would require necessary action. The guidance is available at: tinyurl.com/P4nfkxud.

5.6.28 In April 2019, the Government launched a consultation on proposals for a LA register of children not attending mainstream or registered independent schools, and support for home-educating families (should they want it). This closed on 24 June 2019. LCC awaits responses to a commitment for a mandatory system for children not in school. The system will help LAs undertake their existing duties, as well as help safeguard all children who are in scope. LCC currently operates a database of all Lancashire children and young people who are removed from roll for the purpose of EHE. An annual contact is made, and request to provide examples of suitable education are made. This is not a mandatory request.

5.6.29 Actions from LCC:

- Consultation on LCC EHE guidance and appropriate updates to documents and public information (website, leaflets, letters to parents/carers)
- Children's Champion posts established to work with families where the decision to EHE has not been in the best interests of the child/young person (off rolling by a school).
- Peer supervision regarding cases where a concern is raised.
- EHE support workers have improved learning opportunities – attending Children missing from education and missing from home panels.
- New processes in place for working with SEND/Inclusion teams regarding EHCP/EHE pupils. TASS locality groups – key line of enquiry (key CYP plan priority) = numbers of EHE pupils across the partnerships, hot spots of EHE data which may highlight school practice or pocket of cultural responses to LA based educational provision.

5.7 Assessment and Management of FAB's Risk To The Children.

<u>The National Probation Service involvement with FAB</u>

5.7.1 Following his conviction in August 2015 for possession of indecent images of children, FAB was sentenced to a three year community order that included a requirement to complete an internet offender treatment programme(i-SOTP). The order and programme were overseen by the National Probation Service (NPS). Additionally, FAB was also made the subject of an indefinite. Sexual Harm Prevention Order/SHPO (conditions related to the use of devices that can browse the internet) and required to sign the sex offenders' register for five years. This was overseen by the MOSOVO (Management of Sexual Offenders and Violent Offenders) team of the Lancashire Constabulary. Subsequently, in August 2018 this team took on the role of lead agency, following the ending of the i-STOP

programme in October 2016 and the three year community order to the NPS in August 2018.

5.7.2 The NPS completed an OAsys (offender assessment system) assessment post FAB's conviction, designating him as a Medium Risk of serious harm to children.[17] [18] The resulting risk management plan (RMP) of the 28.10.15 stipulated (amongst other things) that , there would be regular contact with the dangerous and sexual offenders' unit (the DASOU, later known as the MOSOVO), regular review of the RMP, discussion of the case in regular supervision/risk meetings and contact with CSC in the event of any child protection issues, such as FAB moving back into the family home or unsupervised contact with the children. Home visits, both announced and unannounced were to be completed as and when considered appropriate.

5.7.3 The evidence suggests that the 2015 RMP was poorly executed in so far as there was no documented liaison with the MOSOVO in 2015-2016, no annual reviews until the 12.06.18- therefore none done during the period of the child protection plans of July 2016-April 2017- and no record of any home visits in 2016-2018. Given the reason for the ICPC in July, namely the MOSOVO's concern that FAB had downloaded pictures of child B on his phone and his unhealthy sexual interest in pre-pubescent children; this review questioned why this episode did not result in an updated OAsys (dynamic) risk assessment and review of the RMP in the latter half of 2016? Indeed, why was not FAB dealt with as in serious breach of his community order and other ongoing sanctions?[19]

5.7.4 Arguably, the episode should have resulted in a raised risk profile for FAB, closer working with the MOSOVO and the CSC, unannounced home visits and triangulation visits to speak to MAB and the children. A more professionally curious and investigative approach through the visits could have provided more insight into the nature of the relationship between the parents and a better understanding of FAB's contact with his children. Moreover, the episode and its raised risk implications for the children appeared not to have been reflected in the probation reports for the ICPC and the two RCPCs, the second of which resulted in the children being de-planned.

5.7.5 In any event, FAB completed the i-SOTP in October 2016 with a positive programme report. A post programme review (but not constituting an annual OAsys case review) was held on the 01.11.16. evidencing his improved self-management and problem solving, together with his improved strategies to manage his sexual fantasies. There was a NPS post programme (i-STOP) handover meeting on the 01.11.16 when a new offender manager (OM2) was assigned to FAB

[17] See note 4 above for the definition of medium risk.

[18] All registered sex offenders fall within MAPPA (multi-agency public protection arrangements). However, because FAB was assessed as being at medium risk of harm he was designated at level 1 which is local case management as opposed to multi-agency meetings at levels 2 and 3. His medium risk status would not have resulted in a higher level and hence no multi-agency oversight.

[19] The episode also raises the question of why the Lancashire Constabulary appeared not to have considered whether to prosecute FAB for a possible sexual crime regarding child B, especially given he was already a registered sex offender and subject to a community order?

to see out his three year community order. This coincided with the period of the children's child protection plans when the NPS had been part of the core group and had attended the ICPC and the first RCPC. The last recorded home visit (presumably by OM2) to FAB was made on the 13.12.16, thereafter, it seems that all direct contact was office based. This was despite the risk management plan as mentioned above.

5.7.6 In line with national standards, FAB was seen monthly throughout 2017 by OM2 except for February when he failed to attend. This was re-arranged to early March resulting in two contacts during that month.

5.7.7 Between January to the middle of June 2017, FAB was seen at OM2's office. OM2 did not attend the second RCPC in early April 2017[20] but provided a generally positive report on FAB's progress and assigned medium risk status which contributed to the decision to de-plan the children. The report's positivity seemed mainly to be based upon FAB's compliance with and completion of the i-SOTP programme which was entirely based on self-reporting. Following the ending of the child protection plans in April, liaison and communication between OM2 and the children's social worker deteriorated. FAB told OM2 at an office visit on the 25.04.17 that CSC had agreed to him having contact with his children, albeit supervised by their mother, ' outside of the house'. FAB visited OM2 on the 13.06.17 to say that he was seeing his children twice a week outside of the house. OM2 said that he was trying to contact CSC to clarify the contact issue.

5.7.8 OM2 tried contacting the social worker on several occasions to clarify the children's contact arrangements with FAB and how these would be monitored given that CSC had finished its involvement with the family, but, for reasons unknown did not receive a timely response. OM2 did not receive the minutes of the RCPC and thus had no written rationale for the ending of the child protection plans or clarity around the contact issue. Again, the reason for this is not known.

5.7.9 OM2 escalated the request (in writing to CSC) for clarification of contact in June - August 2017 and received a written response from CSC in September 2017 confirming that MAB was able to supervise FAB's contact with his children, ' in the community rather than in the home'. It was noted that the CSC assessment was predicated on the assumption that the parents were not in a relationship with each other nor either with someone else. In the event of a relationship resumption or a new relationship with an other, the risk to the children would need to be reassessed. OM2 showed good practice in escalating the request for further information from CSC.

5.7.10 This information should have resulted in an annual review of the OAsys risk assessment and management plan given the change in circumstances. This was relevant in regard to the unanswered question of how the contact was to be monitored in the absence of any CSC involvement. There was no indication that any thought had been given to this at the final RCPC. Greater liaison with the MOSOVO and triangulation visits, as mentioned above, to the family could have

[20] The RCPC had originally been set for March 2017 but was postponed to April 2017.

provided a better understanding of how contact was progressing and whether it was being supervised safely by MAB.

5.7.11 FAB was recorded as having been seen by his OM on the 16.01.18. He told OM2 that he had been visited by a MOSOVO officer on the 07.01.18 and was also now seeing his children at their maternal grandmother's home. OM2 was also aware from FAB that child A was being home schooled.[21] These volunteered pieces of significant information should have raised concerns and questions from the NPS about the safety of the children and contact with CSC (such as a safeguarding referral), the Police (MOSOVO team) and school X. The removal by MAB of child A from school X in September 2017 took away a significant source of support for her, in addition to the withdrawal of a key line of safeguarding defence, namely the monitoring of her safety and wellbeing.

5.7.12 The OM's omission to inform the CSC regarding child A's home schooling marked a missed opportunity to have safeguarded the children and promoted their wellbeing.

5.7.13 On the 01.05.18 FAB told OM2 via telephone that he was seeing the children a lot of the time at the maternal grandmother's home or, on occasions, at MAB's cousin's house nearby. A second, overdue OAsys risk review and accompanying RMP was done on the 12.06.18, the last one having been completed on the 29.10.15 and clearly not compliant with NPS national standards.

5.7.14 The risk of harm to the children remained unchanged at, ' Medium'. There were no enquiries concerning the arrangements for contact with the children, no visits to the homes of FAB and the children; and no recorded triangulation with the MOSOVO team, CSC or school X to corroborate what FAB was telling OM2. Given FAB's self reported real world sexual interest in children; risk assessment and accompanying RMPs should have addressed his desires beyond the internet, upon which there was, arguably, an over focus. With high levels of arousal, exploring potential outlets to this was an essential element of his risk management.[22] It seemed that there was a lack of an investigative approach, insufficient professional curiosity and inattention to the children's safeguarding needs. OM2 was taking at face value what FAB choose to tell them.

5.7.15 FAB visited the NPS office on the 26.08.18, having last been seen on the 16.01.18. The existing RMP had stipulated FAB be seen monthly. He told OM2 that he was applying for the indefinite SHPO to be ended and said that the Police had indicated that they would not, ' fight against it'. This review was told by the panel police representative that the agency had no record of this statement. If granted, FAB would approach the CSC to see if he could have unsupervised contact with the children.

[21] According to the NPS agency report at page 5, 'The children's voices and lived experience' section.

[22] Taken from the NPS agency report for this review, page 5.

5.7.16 He told OM2 that he was no longer seeing the children at MAB's sister's home.[23] This was because the CSC were (apparently) involved with the sister's family and he did not want to get involved with CSC again, given his intentions of negotiating with them to see the children unsupervised. Questions should have been asked of FAB as to why he was seeing the children in MAB's sister's home, given that the original arrangement with CSC was that the mother was to supervise contact ' in the community'. He was expecting a MOSOVO visit soon and had not been seen by them since early January 2018.[24]

5.7.17 Consequent to the ending of his three year community order and earlier completion of the i-SOTP, FAB's RMP/OAsys was terminated by the NPS and the case closed on the 11.10.18. The final risk assessment remained at ', Medium'. There was little evidence of management scrutiny or case overview. In any event, the NPS ceased being the lead agency for overseeing FAB with sole responsibility being transferred to the Lancashire Constabulary MOSOVO team by virtue of his continuing SHPO and sex offender registration. The team would take on the tasks of risk assessment and the overseeing of a risk management plan for the duration of the five year SHPO, due to end in August 2020.

5.7.18 In conclusion, the evidence above indicates that the risk assessment and management of FAB by the NPS fell short of accepted national standards and was ineffective in safeguarding and promoting the wellbeing of child A and B. The risk management plan was deficient because;

- There were Insufficient home and office visits. FAB was only seen once at his home on the 13.12.16. He was seen in the NPS office on only four occasions in 2017 and 2018. There should have been regular and unplanned home visits to test out what FAB was telling OM2.
- There was too much reliance placed upon FAB's 'positive' progress whilst on the i-SOTP programme. This was based upon his self-reporting which was taken at face value and no third party corroborative evidence from other sources.
- FAB's sexual interest in children beyond the internet should have been addressed in risk assessment and management.
- FAB appeared to control the information flows enabling him to play off the agencies (NPS, MOSOVO and CSC) against each other and construct misleading narratives that led agencies to assume that other agencies were approving of developments.(e.g that CSC knew about the changing contact arrangements and were content with them, which was not the case.)

[23] NB This was a new development. The children had reportedly been seen by FAB at the maternal grandmother's, cousins, and now maternal aunt's, none of which were compliant with the original condition of contact in the community.

[24] According to Police records he had already been seen by his MOSOVO officer on the 18.08.18, thus raising some potential inconsistencies in his account to OM2.

- There was minimal triangulation and liaison with other agencies such as the Police (MOSOVO team),[25] CSC and School X regarding several changes in location of supervision (maternal grandmother and aunt and cousin) and knowledge of child A's home schooling. Minimal corroboration of what he was telling NPS.
- Insufficient professional curiosity and the lack of a more investigative approach to the risk management of FAB.
- Only two OAsys assessments during the course of the three year community order when this should have been done annually.
- Lack of a,' Think Family', approach to include a more holistic, dynamic risk assessment involving seeing the children to ascertain their views and situation, and assessing MAB's ability to protect. This could have been done on a multi-agency basis with the MOSOVO and CSC.
- Lack of management scrutiny and oversight of OM2's risk assessment and management of FAB.

5.7.19 The review was unable to delve into the contemporaneous agency operating environment to see if there were any systemic barriers to excepted practice. It was however, told that the OM could offer no explanation as to why practice fell short of national standards, save that case loads were high at the time. FAB was perceived as a low priority because of his medium risk assignment and his apparent compliance with the i-SOTP and other conditions. Such were the increased demands from other more high risk cases that corners seemed to be cut in regard to the supervision of FAB by the NPS. This raises the key learning point of agency senior management being aware of when front line practitioners and their line managers are struggling to meet demands and the need, when possible, to ensure that demand matches staff capacity. In short, to ensure that individual practitioners' caseloads are manageable.

The MOSOVO team's Involvement with FAB

5.7.20 MOSOVO involvement with FAB spanned a period of nearly five years from the start of his SHPO[26] in August 2015 up to his arrest in May 2020. He was classified as a category 1 offender and as such, was subject to at minimum, an annual home visit by the MOSOVO team. In the event, there were nine completed[27] home visits (out of a total of seventeen) done by several officers during this time.

5.7.21 As previously mentioned, the NPS was the lead agency who, in October 2015, had assessed FAB as medium risk. FAB was first visited by two MOSOVO officers on the 23.11.15 and were told by him that he had no contact with children, including

[25] New (2020) guidance has provided for joint working between the NPS and the Police, including information sharing, joint visits, and joint risk assessments and RMPs, see note 33 below.
[26] It was a five-year SHPO.
[27] i.e. FAB actually seen by the officer.

his own, given the involvement of CSC at the time. There was no relevant safeguarding information recorded and he was assessed as Medium risk.

5.7.22 FAB was next seen on the 28.06.16. He disclosed to the MOSOVO officers that he had an inappropriate sexual interest in pre-pubescent girls. His mobile phone was examined and found to contain several pictures of MAB naked whilst breast feeding child B. He told the officers that she thrived off shock type photographs and apparently posted them onto Facebook. She was well aware of his sexual interest in children. The officers noted that MAB was supposed to be supervis-ing FAB's contact with his children yet was sending inappropriate pictures on line. Moreover, child A was being home schooled. There were also concerns about the physical state of the house suggestive of the children living in neglectful conditions.

5.7.23 The officers correctly assessed that FAB's offending behaviour, his unhealthy sexual interest in young girls, MAB's inappropriate behaviour and concerns about her ability to protect her children, in addition to child A being home schooled and,' off the radar', of children's services agencies, constituted a high risk to the children. One this basis, a Protecting Vulnerable People (child protection) PVP referral was sent to CSC/ MASH (multi-agency safeguarding hub). This action led to the convening of the ICPC in July 2016 and the subsequent child protection plans for the children. The officers showed very good practice during this episode.

5.7.24 FAB was seen at the end of December 2016 for the third time when nothing untoward was noted. There was no evidence of information sharing with the core group or liaison with the NPS offender manager.

5.7.25 There were a further six home visits made by the MOSOVO team to FAB between December June 2017 and May 2020 when the parents were arrested for possession of indecent images of children and child neglect. This episode repeated the two previous offences in 2016 and 2014.

5.7.26 The MOSOVO completed three further visits between 2017[28] and the 11.10.18 when NPS closed FAB's case and the Police became the single agency responsible for his risk assessment and management. FAB's mobile phone was checked on each occasion with (perhaps not surprisingly) nothing untoward found and he remained at medium risk. Of some significance, he volunteered the information on the three visits in 2017/2018 that he was having contact with his children. Indeed, on the visit of the 18.08.18 he disclosed to the officers that contact was taking place at his mother-in-law's and that child A was being home schooled.

5.7.27 The relevance of this intelligence regarding potential risk to the children seemed not to be recognised by the MOSOVO team. They would have had full knowledge of the case including intelligence from MAPPA (Multi-agency public protection arrangements) and child protection sources. There should have been a dynamic risk assessment undertaken to reflect the new information. In the event, there was no liaison with CSC, NPS or school X to clarify the nature of contact with the

[28] July 2017, January, and August 2018

children and whether there were any restrictions and conditions. Nor were there any recorded visits to the children to ascertain their situation.

5.7.28 It is not known why, apart from the visit in June 2016, the MOSOVO did not recognise, record, risk assess and liaise with the other agencies. Lancashire constabulary were unable to offer an explanation as to why this was the case. The agency has acknowledged that there is learning to be identified from the episode which will be captured in its action plan for this review.

5.7.29 Following the ending of the NPS involvement on the 11.10.18, FAB was seen by the MO-SOVO team in March and December 2019 and finally in February 2020. Two ARMS (Active Risk Management System) [29] assessments were undertaken [30] resulting in the ensuing Risk Management Plans (RMP). The first ARMS in March 2019, noted that, ' supervised contact with his children has been approved by social services and he sees them almost every weekend. His ex-wife has been deemed incapable to supervise the contact; therefore MAB's mother has to be present at all times when children are visiting FAB'.

5.7.30 FAB's self reporting was taken at face value as 'fact', with no attempt to corroborate what he was telling the MOSOVO officers. The RMP contained only one action, namely to check internet capable devices during home compliance visits. There was no action to triangulate with CSC regarding the contact issue, especially in light of FAB's report that he was seeing the children at home on weekends, reportedly supervised by their maternal grandmother.

5.7.31 The second ARMS of February 2020, completed by two different officers from ARMS1, relied once again on self reporting from FAB who, arguably, would have had a vested interest in minimising the significance of the information given at the visit[31], given he wanted to come off the sex offender's register and be able to see his children unsupervised. He was rated as 'low' in all eleven categories[32] with no corroborative evidence to challenge his self-reporting. The significance of FAB's mental health deterioration [33] (depression, anxiety and suicidal thoughts) in December 2019 and his urges of wanting to access indecent images of children, seemed not to have been appropriately considered and factored into the risk assessment.

5.7.32 Rather, FAB's explanation to the officers that the mental health workers, 'over reacted', as at no point did he state that he had strong urgent look at IIOC', was

[29] ARMS provides a national standard for the risk assessment and management planning of sexual offenders. It is a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending and protective factors known to be associated with reduced offending.

[30] Using intelligence from ViSOR (violent offender and sex offender register), the PNC (police national computer) and Sleuth (A crime recording system used by Lancashire Constabulary).

[31] E.G Stating to the officers that the majority of the indecent images were Anime cartoons and not actual girls; this is classic minimisation and part of the offender's denial mechanism.

[32] There are six risk factors (opportunity, sexual preoccupation, offence related sexual interests, emotional congruence with children, hostile orientation, poor self-management) and five protective factors (social influences, commitment to desist, intimate relationships, employment or positive routine, social investment-giving something back). Each factor is rated, low, medium or high and aggregated to provide an overall risk level.

[33] See paragraphs 5.3.17/18 above.

accepted and not challenged or corroborated with the GP or the mental health services to assess its risk significance. Moreover, there were several references in the ARMS report to FAB's children coming to his home at weekends[34] for contact but not staying overnight. Indeed, it was noted that the family was going rock climbing that weekend to celebrate child B's birthday. Again, there was no liaison with CSC to ascertain contact issues.

5.7.33 The ARMS concluded that FAB, ' now presents as a reformed person who puts his children and family first'. Arguably, this was an overoptimistic assessment that was overly focused on FAB's internet activity; that did not take into account the key issues around his recent mental health episode in December 2019 and the contact arrangements with his children. As identified at the practitioners' learning event, there appeared to be too much reliance on FAB's self-reporting and minimal third party corroboration with CSC, the GP and the mental health services.

5.7.34 In sum, there was an over narrow focus on internet related issues (e.g checking the mobile phone for IIOC[35]) and a failure to think more widely (Think Family) about risk to the children who were not seen as part of the assessment. Overall, there was a lack of professional curiosity, little evidence of an investigative mindset and minimal line management oversight and scrutiny. FAB's situation should have been seen within a wider dynamic risk framework involving, not just risk around IIOC and the internet, but risk to his children, given what he was saying and all of the then known factors.

5.7.35 This review notes the guidance from the College of Policing (Managing sexual offenders and violent offenders; authorised professional practice) which states,' An investigative approach, underpinned by respectful scepticism, is central to every stage of managing MOSOVO offenders and PDPs (potentially dangerous offenders).....each case should be assessed on individual circumstances and informed by static and dynamic risk models'. (page 3)

5.7.36 In the lead reviewer's opinion, the current ARMS assessment tool is overly focussed on the offender and their offending behaviour and does not not sufficiently address wider dynamic issues around the offender's family, including children and venerable adults. It is suggested that the College of Policing review the ARMS tool and consider amending it to include wider family dynamics.

5.7.37 In conclusion, the above evidence suggests that the Lancashire Constabulary MOSOVO team risk assessment and management of FAB did not effectively safeguard the children and promote their wellbeing. There may have been organisational barriers to safe practice inherent within the operating environment of the MOSOVO practitioners which need to be identified and addressed (e.g workload and sufficient time to undertake ARMS assessments and follow up work).

5.7.38 <u>Current Developments</u>

As a result of this review the Lancashire Constabulary has developed an action plan that seeks to address the above deficits. Current (2020) ARMS assessment

[34] This was assessed as corroborating the 'fact that he is not overly sexually preoccupied'

[35] As previously noted FAB

guidance and processes now provide for a much greater degree of joint work, liaison and information sharing between the Police and Probation services, including the making of joint visits too offenders.[36] 'Joint working, through positive working relationships and ongoing information sharing, remains key to the effective joint management of registered sex offenders (RSOs). It is therefore important to ensure that relevant information gained from single agency visits and interviews is shared promptly'. (Joint Risk Assessment Flowchart and Guidance, June 2020).

5.8 The School X

5.8.1 Child A attended secondary school X from September 2016 until July 2017 and for most of this time (September 2016 to April 2017) was subject to a child protection plan. The school, whilst not present at the ICPC in July 2016, was a core group member through teacher C. Teacher C attended core groups, produced written and verbal reports and liaised with the social worker via telephone and e-mail. In addition to addressing the relevant safeguarding issues for Child A, efforts were made to increase her attendance via a phased return to school education, having previously been home educated by her mother. She was also supported pastorally by staff during this time. Whilst at school X she was observed to have grown in confidence, making friends and engaging well with her lessons. She made excellent progress with her education and was working above age related expectations in many subjects. She returned to home education in September 2017 at her mother's request where she remained until May 2020.

5.8.2 Teacher C attended the planned final RCPC in March 2017 which was postponed until early April because the CSC reports had not been uploaded onto the system. Teacher C did not attend the rescheduled RCPC due to it being held in the Easter school holiday. A report was provided but the teacher could not recall agreeing to ending the child protection plan. That said, it was the case that Child A's school engagement was improving and there was nothing known at the time to raise any new safeguarding concerns.

5.8.3 Teacher C stated that they did not receive notification of a step down to a TAF plan and consequently did not attend any further meetings in this regard. An e-mail was sent to the social worker on the 21.04.17 stating that, ' I'm aware that the CP Plan has ceased as of the 6th April but is there any further provision e.g CIN, TAF etc' ? No reply was received and Child A continued to be supported through the school's pastoral structure until the end of the summer term in July 2017.

5.8.4 Regarding Child A's voice and lived experience, school X reported that she was able to speak to staff about her welfare and knew that she could confide in them if needed. The phased return to school , which included the provision of two ' peer buddies', was made in response to Child A's (and her mother's) wishes. She attained full attendance in December 2016 and made very good progress, educationally and socially (making new friends), was communicating well with her teachers and appeared increasingly happy and settled in school. It was noted by

[36] See,' Joint Risk Assessment Flowchart and Guidance', and 'Arms Assessment: Police Process'.

the school that she never presented with any behavioural issues and said she was happy in her form group and school.

5.8.5 Overall, the evidence provided for this review would indicate that Child A's re-integration and time at school X were very beneficial for her in all respects, was well handled and child focused. In this respect, it would have been in her interests if the school, along with the Police and probation services, had linked up to monitor her situation via a continued CIN/TAF plan (or arguably, a six months continuation of the child protection plan) to at least see her school attendance through to September 2017. Any safeguarding or welfare concerns, including reversion to home schooling, could have been reported to CSC and appropriate enquiries made.

5.9 The Voice of the Children and their lived experience.

5.9.1 At their express wish, both children declined to meet with the independent reviewer. There is thus, no record of their views about the services received by them.

5.9.2 In the main, there was a poor response by agencies to the extent to which they listened to the voices of the children and understood their lived experience. CSC stated that Child A's views were recorded on statutory child protection visits. She was also involved in direct work around keeping safe. However, because there was no updated child and family assessment during the course of the child protection plan there was little or no evidence of the children's lived experience. Self evidently, expected practice should have resulted in child and family updates, including observations on the children's lived experience.

5.9.3 There was no evidence of Child A's involvement in the ICPC, core groups or RCPCs. Child B was not old enough to have meaningly participated in any meetings.

5.9.4 The Children and Family Wellbeing Service was unable to comment on issues around the children's voices and their lived experience. This would suggest that there were no recordings on this issue which, if correct, needs to be addressed by the agency.

5.9.5 Health visiting records noted on numerous occasions the unsatisfactory home conditions experienced by the children. Interaction with their mother was noted as being appropriate although recordings were limited and not consistent. There was no evidence of their views being directly recorded. Child A was seen by a school nurse for the individual health assessment (IHA) provided for the ICPC but this was in front of her mother. She therefore had no opportunity to speak to the school nurse independently about her wishes and feelings.

5.9.6 As previously mentioned the family's GP service (GP1) had no record of the child protection plans. There was no evidence of any recorded observations during the time in question of the children's wishes and feelings or lived experience. There was a lack of professional curiosity in the primary care mental health consultation with Child A and no exploration of family and home circumstances and parenting capacity. The CCG action plan for this review has provided for inclusion of family and home circumstances in mental health consultations. However, as in the case

of most of the agencies who had contact with the family, there needs to be a greater emphasis on seeking out children and young people's wishes and feelings as per expected practice.

5.9.7 Similarly, there was no evidence of Child A's voice in her involvement with the hospital trust during the two admissions of March and October 2017.

5.9.8 There were no visits undertaken by the EHE service in the relevant time frame and hence no instances of the voices of the children being noted or any observations of their lived experiences.

5.9.9 The only exception to the generally poor practice by agencies regarding ascertaining the children's voices and seeking an understanding of their lived experience was demonstrated by school X as set out in paragraph 5.8.3 above.

5.9.10 Regarding Police and Probation practice this was entirely adult focussed on FAB, lacked professional curiosity and did not consider the children's safeguarding and welfare needs. In this sense there was no child focus shown by these agencies.

5.9.11 In conclusion, the evidence indicates that, with the exception of school X, agencies' practice was insufficiently child focused, did not allow for the children's voice to be heard and fell short of reaching an acceptable level of understanding of their lived experience.

5.10 Disguised Compliance

5.10.1 The parents disagreed with the child protection plans being made following the ICPC in July 2016. However, there was negligible evidence of disguised compliance[37] by them following the first RCPC in October 2016 and up to the ending of the plans in April 2017. CSC state that there should have been more professional curiosity shown by way of unannounced social work visits to the family home to establish that FAB was not there. This review would agree with the suggestion.

5.10.2 Following the ending of the child protection plans in April 2017, there was evidence known to agencies- but not acted upon that MAB was not keeping to the agreed arrangements regarding FAB's contact with the children, namely that he was not seeing them, ' in the community', and supervised by MAB. Her decision to revert back to home education for the children in September 2017, deprived them of a reasonable standard of education and isolated Child A from the protective and beneficial environment of school X. The action also resulted in Child B missing out on the key stages of early years and primary education.

5.10.3 In conclusion, there was little direct evidence of parental disguised compliance, albeit a more professionally curious approach might have detected this. The parents' decision to breach the child contact agreement and MAB's reversion to home education were examples of overt non-compliance and were not congruent with their children's safety and wellbeing.

5.11 Good Practice

[37] Defined as, 'involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement'. (NSPCC; Disguised compliance, learning from case reviews)

5.11.1 This was evidenced by (1) OM2 escalating the request for further information from CSC and (2) The excellent risk assessment done by the MOSOVO officer following the home visit to FAB in June 2016 leading to the ICPC of July 2016 and the resulting child protection plans.

5.12 Family Views (see appendix 4)

5.12.1 The lead reviewer met with MAB, along with her health worker, in October 2021. At the time of writing (05.01.22) arrangements are in train to see FAB in prison.

5.12.2 Key learning issues that emerged from MAB's perspective included,

- An unrealistic and over-optimistic professional perception of MAB's ability to safely supervise her children's contact with their father.
- A greater understanding of her mental health issues and the implications for the risk assessment.
- The need to provide MAB with full details of FAB's offending behaviour in helping her understand the risks he presented to the children.
- The need for an independent and more specialised professional to help her and the children better understand FAB's risks.
- The need for professionals to consider the possibility of domestic abuse and coercive control in the parental relationship.
- The need to ensure that parents fully understand the rationale and purpose of child protection and team around the family plans and their role in implementing them.
- For schools to address bullying.
- For EHE services to follow up letters with contact and help when requested.

6. Key Findings and Learning

6.1.1 The implementation of the child protection plans was mixed. On the one hand they did keep the two children safe from sexual abuse and neglect; their health and development were positive and Child A benefited from being at school.

6.1.2 However, the lack of unannounced visits as per the plans, inconsistency of attendance by core group members, little evidence of eliciting the children's wishes and feelings and changes mid way with the IRO, were flaws in the plans' implementation.

6.1.3 Lesson 1: If part of the child protection plan, unannounced visits should take place. There should be consistency with core group membership, IRO oversight and challenge.

6.1.4 The rationale for the ending of the plans in April 2017 was based upon the positive reports from core group agencies, the police and probation. A key factor was the assessment of MAB's ability to protect her children and safely supervise contact in the community with their father. Arguably, the assessment underestimated the risk and would have benefited from a specialised assessment from an external agency (which is currently the case), in

addition to a more integrated approach capturing the risk assessments from the police (MOSOVO) and probation services.

6.1.5 An integrated approach between CSC, the Police (MOSOVO) and the probation service,[38] (also including the school X and the family GP) could have led to a robust risk management arrangement -possibly within a step down CIN plan-regarding MAB's supervision of the children's contact with their father, following the end of the formal child protection plans. Any significant con-cerns or changes (e.g Child A being taken out of school X for home schooling) could have triggered an alert to CSC who could have made appropriate enquiries into the children's safety and welfare

6.1.6 Lesson 2: Where there are uncertainties about risk management following the ending of child protection plans, consideration, where appropriate, should be given to promoting a multi-agency approach, via a CIN/TAF plan.

6.2.1 There was no clear rationale for the TAF plan recorded in either the CSC child and family assessment or the final RCPC minutes. School X was not included in the plan. In the event, the three weeks TAF served no useful purpose in regard to promoting the safety and wellbeing of the children.

6.2.2 Lesson 3: The rationale for all step down plans should be (I) recorded in CSC child and family assessment plans and RCPC minutes, (ii) subject to management oversight, agreement and rec-orded reasons regarding closure.

6.3.1 The school nursing and health visiting services (when part of Trust 1) fell short of expected safeguarding practice in respect of, a lack of child focus, professional curiosity and a failure to fol-low up on the needs of the children. There were several missed opportunities to have seen the chil-dren, assessed their needs, safety and wishes and feelings in the period after the end of the child protection plans. The underlying systemic reasons for these safeguarding deficiencies was not available from the previous Trust 1.

6.3.2 Trust 2 has since identified the relevant learning and practice improvements from this review and has implemented an action plan aimed at securing the safety and well-being of children in its remit.

6.4.1 The two GP practices fell short of providing an acceptable level of safeguarding intervention to the children. It was concerning that GP1 had no record of the children's child protection plans nor did it provide any information to the ICPC or core group. GP2's omission in contacting CSC in De-cember 2019 regarding FAB's admission, amongst other things, of having strong urges of access-ing illegal images of children on the internet, also marked significant shortcoming in safeguarding practice.

6.4.2 These episodes suggested (2016/17 for GP1 and 2019 for GP2) a lack of safeguarding awareness, effective information sharing/recording systems and professional curiosity tantamount to significant disconnect between the two practices and the local multi-agency safeguarding system.[39]

6.4.3 Lesson 4: The two GP practices need to ensure the local CCG and the Lancashire safe-guarding partnership that they are now fully compliant with all relevant safeguarding proce-

[38] Under the auspices of the Sexual Harm Prevention and three year supervision orders.

[39] But see appendix 5 for actions taken by the CCG and recent improvements made.

dures.These would include, information sharing, knowledge of a child's safeguarding status, safe-guarding awareness, professional curiosity and when to refer to CSC regarding a child being poten-tially at risk of significant harm.

6.5.1 The Child Psychological Service: Safeguarding practice was sub-standard as evidenced by the service not including safeguarding considerations in the psychological assessment of Child A in November 2017 and not contacting CSC. This was despite being told by MAB of the recent child protection plans and FAB's sexual crimes background. This review has had sight of the health trust's key learning and action plan and is satisfied that all relevant lessons have been identified and have or are in the process of being implemented.

6.6.1 Regarding hospital H1, the actions taken by ED staff regarding the two contacts with the child B in 2017 were compliant with expected agency safeguarding policy and practice.

6.7.1 The EHE team's practice-notwithstanding any possible organisational barriers within the oper-ating environment of the practitioners-was ineffective in both ensuring the suitability of child A's ed-ucation and promoting their safety and wellbeing. There was an overall lack of awareness regarding the children's safeguarding and wellbeing.

6.7.2 Practice was marked by an element of, 'silo working', and lack of professional curiosity, The EHE team should have challenged the suitability of home education ostensibly being offered to child A. This could have resulted in any safeguarding concerns being referred to CSC.

6.7.3 The EHE service lacked a protocol setting out clearly a pathway ensuring that children being home educated received a suitable and efficient education, consistent with their safeguarding needs.

6.7.4 Lesson 5: The LCC EHE service should provide guidance, including an integrated decision and action pathway, that enables professionals to assess that EHE children are receiving a suita-ble and efficient education, that also meets any safeguarding needs.[40]

6.7.5 Lesson 6: The EHE service needs to ensure the Safeguarding Assurance Partnership that, in respect of home educated children and young people, current policy and practice is compliant with national and local safeguarding policies and procedures.

6.7.6 Lesson 7: The DfE should produce practitioner guidance that seeks to integrate EHE and safeguarding policy and practice, including an integrated decision making flowchart. The guidance should be included in the next editions of ' Working Together to Safeguard Children' , ' Keeping children safe in education' and 'Elective home education'.

6.7.7 Lesson 8. There are compelling reasons for the adoption of mandatory local authority registra-tion of all home schooled children. The lead reviewer would respectfully argue for the adoption by the DfE of all of the measures called for by the Children's Commissioner as set out in paragraph 5.6.12 above.

6.8.1 Regarding the NPS, the risk assessment and management of FAB fell short of national standards and was ineffective in safeguarding and promoting the wellbeing of the children. There was a lack of an investigative approach, insufficient professional curiosity, too much reliance on FAB's self reporting, an over focus on his internet activity, a lack of a more holistic and dynamic approach to risk, no unannounced home visits, a lack of liaison with the Police

[40] See for example the summary of Manchester City Council Elective Home Education Process, November 2019, see also, Manchester City Council Directorate of Children and Families: Elective Home Education Policy and Practice.

MOSOVO, CSC and school X, no triangulation with family visits and inattention to the children's safeguarding needs.

6.8.2 The practice deficiencies arose, partly as a result of the OM having to cut corners due to a reportedly high case load which led to FAB's supervision being deemed as low priority.

6.8.3 Lesson 8: NPS supervision of offenders should be adequately resourced. Practice should be informed by a more holistic approach to assessment and risk management planning that is dynam-ic, includes a focus on children (and when relevant, vulnerable adults), liaison with other agencies, effective line management oversight and professional curiosity beyond the index offence.

6.9.1 The Lancashire Constabulary MOSOVO team's practice in regard to risk assessment and management of FAB did not effectively safeguard the children and promote their wellbeing. There was an overly narrow focus on internet related issues (e.g checking the mobile phone for IIOC) and a failure to think more widely (Think Family) about risk to the children who were not seen as part of the assessment.

6.9.2 FAB's situation should have been seen within a wider dynamic risk framework involving, not just risk around IIOC and the internet, but risk to his children, given what he was saying and all of the then known factors. Consideration could have been given to seeing the children and eliciting their views after the ending of the child protection plans.

6.9.3 There was a lack of professional curiosity, little evidence of an investigative mindset, minimal liaison with other agencies (NPS, CSC, school X) and apparent shortcomings with line manage-ment oversight and scrutiny.

6.9.4 The current ARMS assessment tool is overly focussed on the offender and their offending behaviour and does not not sufficiently address wider dynamic issues around the offender's family, including children and venerable adults. It is suggested that the College of Policing review the ARMS tool and consider amending it to include wider family dynamics and additional corroborative evidence beyond offender self reporting.

6.9.5 Current (2020) guidance on OAsys/ARMs assessment and risk management plans provides for joint working and information sharing between the MOSOVO and NPS offender managers.

6.9.6 Lesson 9: Lancashire Constabulary MOSOVO should inform its practice by a more holistic approach to assessment and risk management planning that is dynamic, includes a focus on chil-dren (and when relevant, vulnerable adults), liaison with other agencies, effective line management oversight and professional curiosity beyond the index offence.

6.9.7 Lesson 10: The College of Policing should review the ARMS tool and consider amending it to include wider family dynamics and additional corroborative evidence beyond offender self reporting.

6.10.1 Child A's re-integration and time at school X were very beneficial for her in all respects, was well handled and child focused. In this respect, it would have been in her interests if the school, along with the Police and probation services, had linked up to monitor her situation via a continued CIN/TAF plan (or arguably, a six months continuation of the child protection plan) to at least see her school attendance through to September 2017. Any safeguarding or welfare concerns, includ-ing reversion to home schooling, could have been reported to CSC and appropriate enquiries made.

6.11.1 Excepting school X, agencies' practice was insufficiently child focused, did not allow for the children's voice to be heard and fell short of reaching an acceptable level of understanding of their lived experience.

6.12.1 There was little direct evidence of parental disguised compliance, albeit a more professionally curious approach might have detected this. The parents' decision to breach the child contact agreement and MAB's reversion to home education for child A were examples of overt non-compliance and were not congruent with their children's safety and wellbeing. A more pro-active and investigative approach by agencies (principally, NPS and the MOSOVO) could have mitigated the parents' non-compliance.

6.13.1 Good practice was evidenced by, OM2 escalating the request for further information from CSC; and the excellent risk assessment done by the MOSOVO officer, following the home visit to FAB in June 2016, leading to the ICPC of July 2016 and the resulting child protection plans.

6.14.1 Lessons from MAB; see paragraph 5.12.2

7. Recommendations

7.1 **Children's Social Care/ Children and Family Wellbeing Service**: lessons 1-3 have been addressed by the agencies' action plans

7.2 **East Lancashire CCG:** Within six months of the acceptance of this review, the two GP practices mentioned in this review should ensure the CCG and the Safeguarding Assurance Partnership that they are now fully compliant with all relevant safeguarding procedures.These would include, information sharing, providing reports when requested, knowledge of a child's safeguarding status including being subject to child protection plans/ child in need plans , safeguarding awareness, professional curiosity and when to refer to CSC regarding a child being potentially at risk of significant harm.

7.3 **Lancashire Elective Home Education Service:** Within six months of the acceptance of this review; the Director of Children's Services should require,

- the EHE service to provide guidance, including an integrated decision and action pathway, that enables professionals to assess that EHE children are receiving a suitable and efficient education, that also meets any safeguarding needs and which is subject to the prevailing legalities and statutory provisions.
- assures the Safeguarding Assurance Partnership that, in respect of home educated children and young people, current policy and practice is compliant with national and local safeguarding policies and procedures.

7.4 **National Probation Service; North West Division:** Within six months of the acceptance of this review, the Chief Officer of the NPS North West Service, should take all necessary steps to assure the Safeguarding Assurance Partnership that offender manager practice of sex offenders be informed by a more holistic approach to assessment and risk management planning, that is dynamic, includes a focus on children (and when relevant, vulnerable adults), liaison with other agencies, effective line management oversight and professional curiosity beyond the index offence.

7.5 **Lancashire Constabulary:** Within six months of the acceptance of this review, the Chief Constable should assure the Safeguarding Assurance Partnership that the MOSOVO inform its practice by a more holistic approach to assessment and risk management planning that is dynamic, includes a focus on children (and when relevant, vulnerable adults), liaison with other agencies, effective line management oversight and professional curiosity beyond the index offence.

National Recommendations

7.6 It is suggested that the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership request that through the good offices of the Child Safeguarding Practice Review Panel, the following recommendations are presented to the Department for Education and The College of Policing. Moreover, that within six months of the request, the Child Safeguarding Assurance Partnership receives a response from the two organisations setting out their respective actions (if any) to the recommendations.

7.7 **The Department for Education:** The DfE should produce practitioner guidance that seeks to integrate EHE and safeguarding policy and practice, including an integrated decision making flowchart. The guidance should be included in the next editions of ' Working Together to Safeguard Children' , ' Keeping children safe in education' and 'Elective home education'.

7.8 **The Department for Education:** The Department should adopt all of the measures called for by the previous Children's Commissioner as set out in paragraph 5.6.12 above.

7.9 **The College of Policing:** Within six months of the acceptance of this review, the college should review the ARMS tool and consider amending it to include wider family dynamics and additional corroborative evidence beyond offender self reporting.

8. Glossary of Terms

Family
Child A
Child B
MAB: Mother of the children
FAB: Father of the children

ARMS: Active risk management system
CCG: Clinical Commissioning Group
CFW: Child and family welfare
CIN: Child in Need
CRAT: Child risk assessment tool
CSAP: Child safeguarding assurance partnership
CP-IS Child protection information system
CSC: Children's social care
CSPR: Children's safeguarding practice review
DASOU: Dangerous offender and sex offender unit
EHE: Elective home education

ELCAS: East Lancashire child and adolescence service
ELHT: East Lancashire hospital trust
HV: Health visitor
GAD: General admission document
GP: General practitioner
ICPC: Initial child protection conference
IHA: Individual health assessment
IRO: Independent reviewing officer
IILC: Indecent images of children
I-SOTP: Internet sex offender treatment programme
LCC: Lancashire County Council
MAPPA: Multi-agency public protection arrangements
MASH: Multi-agency safeguarding hub
MOSOVO: Management of sexual offenders and sexual offenders team
NPS: National probation service
OAsys: Offender assessment system
OM: Offender manager
PVP: Protection of Vulnerable People
PNC: Police national computer
RCPC: Review child protection conference
RMP: Risk management plan
SEN: Special educational needs
SHPO: Sexual harm prevention order
START: Specialist triage, referral and treatment team
SW: Social worker
TAF: Team around the family
ViSOR: Violent and sexual offender register

9. References

- Children's Commissioner (February 2019): Skipping School: Invisible Children
- College of Policing; Managing sexual offenders and violent offenders, authorised professional practice
- Department of Education: Elective Home Education guidance (April 2019)
- Department of Education: Working Together (2018)
- Department of Education: Keeping Children Safe in Education (September 2021)
- Manchester City Council: Elective home education policy
- National Offender Management Service: Public Protection Manual (2016)
- NSPCC: Disguised compliance, lessons from reviews

10. Appendix 1: Aims, Terms of Reference and Key Lines of Enquiry

10.1 The overall aims and objectives are ;

1. To identify learning and improvements to safeguard and promote the welfare of children; and consolidate good practice by understanding why agencies involved with the children A and B were unable to safeguard them from sexual abuse and neglect when these came to light in May 2020.
2. To determine whether decisions and actions in the case complied with the policy and practice of named services and the CSAP.
3. To examine the effectiveness of information sharing, case handovers, transfers and working relationships between and within agencies.
4. To identify how practice can be improved through systemic changes within the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership, to prevent/minimise the reoccurence of what happened to the children.
5. For the CSAP and partner agencies to translate the findings of the Review into a programme of action that lead to sustainable improvements and the prevention of serious injury and harm to children.

10.2 Key Lines of Enquiry (KLOE)

1. The Child Protection Plan: How well was it implemented and reviewed by the core group and IRO service? What was the rationale for ending it in April 2017? What was the basis for assessing that the mother could safely supervise (in the community) father's contact with the children; how realistic was it given all of the known risk factors at the the time? (CSC, core group agencies and IRO service)
2. The Team around the Family (TAF) Plan: What was the rationale for stepping down from the CP Plan to a TAF plan; was a Child in Need plan considered and what was the rationale for ending the TAF after only three weeks? What changes have been made to the stepping down process since April 2017 and how effective are current arrangements in ensuring the safety and wellbeing of children? (CSC, CFW service)
3. Effectiveness of Universal Services (LSCFT: Health visiting and School Nurse services): How effective, or otherwise, were the health visiting and school nurse services in safeguarding and promoting the welfare of the children? What were the reasons why they seemingly, fell short of acceptable and safe practice?
4. The Voices of the Children and their Lived Experience: How well did the agencies listen to the voices of the children and understand their lived experience whilst in the care of their mother? (All agencies.)
5. Disguised compliance: To what extent, if at all, was disguised compliance by the mother a feature in this case? If so, was it recognised by the agencies and if not, why not? (All agencies involved with the CP and TAF plans)
6. Assessment and management of FAB's risks to the children: How effectively was FAB's risk jointly and singly assessed and managed by the Lancashire Constabulary MOSOVO and

the NPS in regard to the children? What was the rationale for grading FAB as a low risk? How effective was information sharing by the MOSOVO with child protection and mental health services regarding potential risk to the children from FAB? What role did the probation service play in managing FAB's risks to the children? (Lancashire Constabulary and National Probation Service)

7. School: How effective was Child A's school in liaising with other agencies and contributing to the multi-agency effort at safeguarding and promoting Child A's education and wellbeing? Why did Child B not get onto the school roll and start primary school in 2018? (School, Education service)
8. Elective Home Education: What was the rationale of the EHE service in not challenging the mother's wish to educate Child A at home in September 2017, given (i) the recent concerns about sexual abuse, neglect and poor school attendance,(ii) evidence that Child A's attendance was improving when she was on roll at the school and that she was performing well educationally? How effectively did the EHE service intervene to safeguard Child A and ensure she was being adequately educated? (EHE service)
9. GPs: How well did the two GP practices (mother's/children and father's) contribute to the safeguarding and promotion of the children's welfare, including (i) any information sharing issues and (ii) bearing in mind that neither child's child protection plans were on their patient records? If well, why; if not well, why? (GPs/CCG)
10. Children's Psychological Services (LSCFT): How well was the initial assessment on Child A undertaken in relation to any potential issues? If well, why; if not well, why? Why was there no triangulation with CSC to verify the mothers' account of supervised weekend contact with the father?
11. Hospital Safeguarding: How well did the ELHT safeguard and promote the children's welfare during their mother's four day hospital admission in October 2017 when Child B attended the ED with his father? Were there any concerns raised at Child B's examination on the 17.10.19 regarding the appropriateness of him being breast fed by his mother at the age of 5years and 8 months? If not, why not? Why did the CPIS not identify that Child B had been a child subject to a CP Plan earlier that year (2017)?
12. Good Practice: Please give examples of any good practice (not expected practice) and say why they were good.

11. Appendix 2: Review Methodology and Process

11.1 The review is informed by elements of the, 'Welsh model' (Protecting Children in Wales, 2012) and the 'Pathways to harm, pathways to protection' framework; (Brandon et al, March 2020, pp 23- 24, NB See 'Serious Case Reviews: Research into Practice, by Peter Sidebotham: seriouscase reviews.rip.org.uk, for an excellent video presentation of systems methodology and the pathways to harm model.

11.2 The systems approach seeks to move beyond a focus on the level of the individual practitioner towards a wider and more holistic understanding of the contemporaneous operational (inter and intra agency context) environment in which individual practitioners took actions and made decisions. The approach seeks to provide a critical analysis, at both an inter and intra agency

levels; and looks at the organisational barriers and enablers (layers of defence) that either hinder or empower practitioners to make safe decisions and take actions that lead to optimum or adverse safeguarding and welfare outcomes for children.

11.3 However, by way of a caveat, many of the key events in this case (e.g the child protection plans of July 2016/April 2017) occurred several years ago. Because of the passage of time and the fact that some key professionals are no longer around, it has been problematic to obtain an accurate and first hand account of practitioners' operating environment. This has made for difficulties in providing a systemic analysis to the extent originally envisaged.

11.4 The CSPR was independently chaired and led by Mr. Paul Sharkey who had no previous direct connections with any of the Lancashire agencies involved with the family. He is an experienced reviewer from a social care/safeguarding/public protection background in both the statutory and third sector. He worked with a panel made up of senior managers from the involved agencies and met three times between January and October 2021.

11.5 The review was informed by:

- Individual agency reports
- Relevant documentation such as ICPC/RCPC minutes and Police risk assessments
- An online practitioners' learning event in June 2021
- A real world meeting with MAB
- Critical feedback on several report drafts by the panel

12. Appendix 3: Elective Home Education: Current National Policy and Legalities[41]

12.1 The Association of Directors of Children's Services (ADCS) 2019 EHE survey stated that across 132 local authorities there was a total of 47,464 children and young people known to be home educated as of 3 October 2019.[42] Across the 152 local authorities (the total number of local authorities in England) the estimated numbers amounted to 54,656 children and young people. There was a 20% annual increase in children and young people being home educated in the five years up to October 2019.[43] These figures are likely to be an underestimate given that parents are not currently legally required to register with local authorities that their children are being home educated.

12.2 The survey analysis indicated that an average of 13% of the home educated cohort was known to Children's Social Care (either historically and/or currently) with an average of 18% known to wider Children's Services. Thus, nearly a third of the known cohort had some contact with

[41] See,' Home education in England' (10.01.2022-House of Commons Library) for an excellent and up to date review of home education.

[42] Since updated to around 81,200 registered children in England as of October 2021 (Home education in England (January 2022)). The estimate is very likely to be an underestimate because registration is voluntary.

[43] The 2020 EHE census (taken on the 1 October 2020) gave an estimated figure of 75,668 children and young people being home educated across the 152 local authorities. This marked an estimated increase of 38% from the October 2019 census. The main reason given by parents for home educating their children was due to health reasons directly related to covid 19.

Children's Services. Children at key stages 3 and 4 (secondary schooling) are the two largest cohorts. A majority of local authorities (103 out of 116) stated that the size of their EHE cohort relative to the wider school population was between less than 0.5% up to 1.0%.[44] In the North West region of England there was estimated to be an average of 370 known EHE children per local authority.[45]

12.3 Parent's Rights to Educate

Parents have a right to educate their children at home as set out by section 7 of the Education Act 1996 requiring:

"The parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable

(a) to his age, ability and aptitude, and

(b) to any special educational needs he may have, either by regular attendance at school or otherwise."

12.4 Parents thus have a duty to ensure their children are educated. If they do educate children at home, section 7 means that the child should be getting an efficient, suitable fulltime education. However, the legislation does not differentiate between school attendance or education 'otherwise' (i.e without school). In short, education is compulsory for children between 5 and 16 but going to school is not. Moreover, the terms "efficient" and "suitable" education are not defined in law, de-spite the detailed prescription of expectations in schools. Case law[46] has broadly described an "efficient" education as one that "achieves that which it sets out to achieve". A "suitable" education is one that,

"primarily equips a child for life within the community of which he is a member, rather than the way of life in the country as a whole, as long as it does not foreclose the child's options in later years to adopt some other form of life if he wishes to do so".

12.5 In England, if a parent wants to home educate their child (by removing them from school) they are not required to notify the local authority, they need merely to write a letter to the school informing them of the fact (as with child A). The school must then notify the local authority. Children who have never been to school/been on a school roll (as with child B) or who move area, may not be known to the local authority. Thus, children educated at home may never

[44] See paragraph 2.8, page 6 of the ADCS's 2019 survey

[45] According to the ADCS EHE survey report, November 2020, Appendix 1, page 10, EHE cohort summary per region, North West, based on 18 out of 23 responding local authorities.

[46] Mr Justice Woolf in the case of R v Secretary of State for Education and Science, ex-parte Talmud Torah Machzikei Hadass School Trust (12.4.85)

have attended school and could be invisible to education and health professionals and never come under the local authority's,' radar'.[47]

12.6 Local Authority Obligations and Duties

Local authorities under section 436A of the Education Act 1996 must make arrangements to find out so far as possible whether home educated children are receiving suitable fulltime education. (DfE; EHE Guidance: April 2019; non statutory). Thus, whilst having an obligation to identify children who are not receiving a suitable education, they have no legal duty to monitor home-educators or any powers to insist on visiting the home to carry out checks on the quality of the education, unless under safeguarding laws there are welfare concerns. This poses a problem for local authorities charged with a statutory duty under section 437(1) Education Act 1996 in that they are required to intervene:

" If it appears to a local education authority that a child of compulsory school age in their area is not receiving suitable education, either by regular attendance at school or otherwise, they shall

serve a notice in writing on the parent requiring him to satisfy them within the period specified in the notice that the child is receiving such education".[48]

12.7 Additionally, duties[49] require local authorities to:

"Make arrangements to enable them to establish (so far as it is possible to do so) the identities of children in their area who are of compulsory school age but—

(a) are not registered pupils at a school, and

(b) are not receiving suitable education otherwise than at a school."

12.8 Within current guidance local authorities are "encouraged to address the situation informally" Such an approach may or may not be sufficient. The Badman report (2009) questioned how were local authorities to know what they don't know when they had no means of determining the number of children who were being electively home educated in their area, or the quality of what was provided, without rights of access to the child? For many, perhaps the majority of home educating families, this approach may be sufficient. Badman did not believe that such arrangements were sufficiently robust to protect the rights of all children.

12.9 Local authorities can request information from parents as to the suitability of the education provided to their child but parents are not obliged to respond. In this event, a local authority

[47] Lack of oversight can be disastrous; there have been six children who have died in the last decade where home education was identified as significant (Children's Commissioner: 2019)

[48] Under s.437(1) of the Education Act 1996, local authorities must act if it appears that parents are not providing a suitable education. This section states that:

[49] Section 436A Education Act 1996 inserted by section 4(1) Education and Inspections Act 2006.

can pursue its attendance procedures, including invoking children missing from home procedures and issuing a school attendance order (SAO) , prosecution (or an Education Supervision Order) and or/fines. However, the process can take months and arguably, the SAO's are too weak (Children's Commissioner:2019)

12.10 "There are no detailed legal requirements as to how such a system of oversight should work, and it is for each local authority to decide what it sees as necessary and proportionate to assure itself that every child is receiving a suitable education, or action is being taken to secure that outcome"

12.11 In any event, the DfE recommends that each local authority:

- should provide parents with a named contact who is familiar with home education policy and practice and has an understanding of a range of educational philosophies;
- ordinarily makes contact with home educated parents on at least an annual basis so the authority may reasonably inform itself of the current suitability of the education provided. In cases where there were no previous concerns about the education provided and no reason to think that has changed because the parents are continuing to do a good job, such contact would often be very brief;
- has a named senior officer with responsibility for elective home education policy and procedures, and the interaction with other work on issues such as children missing education, unregistered settings, vulnerable children, and welfare;
- organises training on the law and the diversity of home education methods for all officers who have contact with home-educating families, possibly in conjunction with other authorities;
- ensures that those LA staff who may be the first point of contact for a potential home-educating parent understand the right of the parent to choose home education. It is very important that parents are provided with accurate information from the outset to establish a positive foundation for the relationship. However, parents are under no obligation to accept support or advice from a local authority, and refusal to do so is not in itself evidence that the education provided is unsuitable;
- works cooperatively with other relevant agencies such as health services to identify and support children who are being home educated, within the boundaries established by data protection and other legislation.

13. Appendix 4: Family (MAB's) Views

Child Safeguarding Practice Review; Child AB

Meeting with MAB in her home held on 20.10.21

Present

MAB: mother to Children A and B

Professional A: Mother's Health Worker

Independent Lead Reviewer: ILR

13.1 ILR introduced himself and explained the purpose of the meeting which was to hear MAB's views on the services offered to her and the children from the start of the child protection plans in July 2016 to their removal from her care in May 2020, following the police intervention. It was not to go over the trial. ILR explained his role in the review which was to provide an independent view and analysis of the agencies' involvement with the children and her in respect of safeguarding. ILR would provide a written draft report with findings and lessons learnt for the agencies to improve their practice and minimise future risk to children involved in similar situations to A and B. MAB would have an opportunity to see and comment on the report before it was to be published by the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership on its website. All names would be anonymised to protect confidentiality. MAB said she understood all of the above and was happy to proceed with the discussion.

13.2 ILR started off asking about MAB's views of the child protection plan (cp plan) of July 2016 to April 2017. MAB said that she understood that the child protection plan was because she had sent pictures of her breastfeeding child B to their father (FAB) who had previously been convicted of downloading indecent images of children. She said that she had not originally understood what could be shared on line with FAB.

13.3 She said that most of the agencies involved in the cp plan had been, ' alright'. However, the social worker was, ' against her', and wanted to keep the cp plan going. The social worker said that MAB needed to come off anti-depressant medication before ending the cp plan. She said that she wasn't ready to stop taking them and thought she had discussed ending her medication with her GP. However, children's social care were , 'outvoted' at the meeting in April 2017 which decided to end the plan. The health visitor was helpful with advice about looking after child B.

13.4 ILR asked about the decision for her to supervise contact between the children and their father in the community. MAB said that now, looking back, she wished that she had not had to do it. She should not have been left to supervise it. Looking back, she had had mental health problems and did not fully understand the risks to her children from their father. She said that she was only told about FAB's conviction in outline and would have found more detail helpful in understanding his risk.

13.5 She said that data protection considerations had limited her knowledge of FAB's sexual offences which had not enabled her to fully understand how best to supervise contact with their father and protect her children. She didn't think that Child B was at risk from FAB. She had thought about getting legal advice but said that she had been told by children's social care that the children would be removed if she did so.

13.6 ILR asked what MAB would have liked the professionals to have done differently. She said that there was an assumption by the social worker that she had fully understood things but this was not the case. She said that it would have been helpful if someone, perhaps an independent advocate, had explained clearly the situation to her and the children so that she would have had a good understanding of what was happening, especially the risk from FAB, who she said was a controlling person.

13.7 ILR asked if there had been any domestic abuse or physical violence from FAB? MAB said that there had been, both mental and physical. PS asked if she had told anyone about this? No she had not because she was wanting to, ' paint a picture of a perfect family'.

13.8 MAB had no clear recollection of what the Team around the Family plan was about.

13.9 ILR moved the conversation onto the children being home educated. MAB said that Child A was getting bullied at her primary school by the teacher; that she was coming home from school crying. This was the reason why home schooling was started in 2016. Child A was and is a clever child and has recently passed several GCSEs. Later on during 2016/17 Child A was subject again to some bullying; being followed home from school, and became unhappy. MAB found her upstairs with a razor blade and was concerned and told the social worker. Child A was asking to be home educated and did not want to continue at the secondary school. MAB decided to once again home educate Child A because of the distress caused by the bullying. She received a letter from the local authority Elective Home Education team but no further contact was made by them. She got support from a local EHE group.

13.10 ILR asked about why child B had not been on a school roll. MAB said that apparently Child B was hyperactive when young and she didn't want him labelled as such, if he had started at a primary school. So she decided to home school him also. PS clarified with her that Child B had had no formal diagnosis of hyperactivity which was the case. Child B is good with numbers but not so good with his reading.

13.11 ILR asked MAB what she thought the lessons were in her dealings with the child protection agencies? She thought the use of an advocate would be helpful and for professionals not to assume that parents were fully understanding of agency concerns about children and whether they (parents) were able to really manage the risk where, for example, they were being asked to supervise contact with offenders, as in this case.

13.12 ILR thanked MAB for her views and said that he would write up the discussion in draft and let her see a copy, via Professional A and have an opportunity to amend it if she wished. Once this had been done to her satisfaction, ILR would include her views and suggested lessons in the final report . MAB said that she felt the meeting had given her a voice.

14. Appendix 5: Improvements in GP Practice and actions taken by East Lancashire CCG

14.1 Current practice in relation to children on child protection plans is outlined in the Royal College of General Practitioner's toolkit. Once informed a child is on a child protection plan – there is a code entered on the EMIS system that puts an alert on the child's records. When a child protection plan is discontinued this alert is removed but the information remains as a historical event on the records. There is a separate alert box on the records that is completed if the child is classed as CIN, has a CAF or TAF plan or any other relevant information.

14.2 The GP records were searched as part of the IMR/Chronology /timeline request and there was no evidence of receipt of the children's child protection plans or ICPC/RCPC minutes. Current day practice would be once received, these are added onto the child's records.

14.3 In terms of ICPC requests to attend /submit information although an invite was not sourced as part of the original records search, current processes are robust around this. The CCG receives the initial request and coordinates attendance/report submission for all ICPC's. This is subject to ongoing audit and scrutiny, and any learning cascaded for all the Safeguarding 'champions'/'leads to disseminate into their practices.

14.4 Each GP practice across East Lancashire has a nominated 'Champion' who attends regular training/update sessions on key safeguarding issues and has responsibility to share with /embed into their practice.

14.5 Safeguarding practice in Primary Care has moved on significantly since the time of these incidents and lessons learnt have been embedded into practice. We have specific Safeguarding Practitioners and Named GP's within the CCG's who work with Primary Care colleagues in developing Safeguarding awareness and offer support around this. We have in East Lancashire as part of the Primary Care contract an identified safeguarding Champion within each practice who is mandated to attend GP Champions training on a quarterly basis (and more frequently if required).

14.6 They also take responsibility for updating policies and processes around Safeguarding in their practice. There is a Sample GP safeguarding policy that CCG's have disseminated into Primary Care, and robust processes for flagging concerns, raising alerts, seeking support, and appropriate referral mechanisms in place. Every GP Practice has to submit an annual SAF (Safeguarding compliance self-assessment tool) to CCG's for oversight and scrutiny. CCG works with any (all) practices who require additional support in key areas or more bespoke training.

14.7 There is an action plan for the two GP practices highlighted in this review that we are working with them with directly, and will offer assurance to CSAP on completion.