Local Safeguarding Practice Review
Case of Amy

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1. Introduction

1.1 This review focuses on Amy who in June 2020 disclosed that her father had sexually abused her over a period of time, dating back to the previous January. At the time of the disclosure Amy was 15 years of age. Amy's father is a Registered Sex Offender (RSO), having been convicted of a relevant offence in 2015.

1.2 Organisations had been involved with the father on his release from serving a custodial sentence and had undertaken assessments to establish the level of contact he could have with Amy and how that contact should be monitored.

1.3 The father had been sentenced to 48 months imprisonment in November 2015 and was released subject to licence conditions to reside with his father in Coventry in September 2017.

2. Terms of reference

2.1 The time period covered by this review commences on 1st June 2017 and concludes at the time Amy disclosed the offences perpetrated against her, in June 2020.

2.2 Agencies that contributed to the review were also asked to consider any information which was outside these time parameters but was relevant to the case in terms of safeguarding or context.

2.3 In addition to generic issues arising, agencies were asked to consider a number of certain areas when undertaking their review and analysis.

- To consider how intrafamilial context is used to assess risk in relation to sexual abuse.
- To understand the effectiveness of interagency working in understanding the risk of sexual abuse.
- To be assured that Amy had an informed voice and that this is captured and informs the assessment.
- The impact of Covid 19 and additional support that young people may need to disclose.
- To consider practitioners assessment of a parent/ carers ability to protect where there is coercion or control.

3. Methodology

3.1 This case was discussed by the Coventry Rapid Review panel in July 2020. The purpose of the review panel under Working Together 2018 is to: -

- Gather the facts about the case, as far as can be readily established.
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.

- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps to take next, including whether or not to undertake a national Child Safeguarding Practice Review or a Serious Case Review.

The panel decided that the case met the criteria for a Child Safeguarding Practice Review (CSPR), and the National Panel agreed with that decision.

3.2 The independent author was engaged in September 2020, and the terms of reference were agreed for the case (appendix A). The below agencies were identified as being involved in the case. Each provided information of their involvement which was developed into a chronology.

- South Warwickshire Foundation Trust (SWFT)
- Children Services (CS)
- National Probation Service (NPS)
- University Hospital Coventry Warwickshire (UHCW)
- West Midlands Police (WMP)
- Coventry Warwickshire Partnership Trust (CWPT)
- Education
- Amicus Health Surgery
- Woodend Health Centre
- Henley Green Medical Centre

3.3 All agencies attended a reflective practitioner's workshop, due to Covid restrictions this event was conducted virtually. To enhance the ability for practitioners to contribute, additional software was used to allow views to be submitted prior to, during and after the event.

3.4 Both Amy and her mother agreed to be spoken to regarding their experiences and views. These are reflected where appropriate in the narrative of the review and within the lived experience of this report.

4. The family

4.1 Amy has three half siblings who at the time of the events which initiated this review were 11, 5 and 3 years of age. The family have been known to Coventry Children Services periodically since 2010, however none of the children have ever been subject to Child in Need or Child Protection Plans.

4.2 In 2011, the family suffered a significant event related to a child who died of a childhood accident and Amy discovered her sibling. This event had a significant impact on Amy throughout her childhood.

4.3 The half siblings had two separate fathers who were not resident with the family at the time of this review.

4.4 Amy attended school, there were no recorded concerns from school, but in June 2019 she was referred to Child and Adolescent Mental Health Service (CAMHS) due to low mood. Amy was accepted into REACH[1]. Amy was able to disclose her low mood to a trusted teacher, who took the appropriate action which led to support.

5. Amy's lived experience

5.1 Amy's mother and father had known each other for some time prior to her birth. Amy was 5 years of age when her mother and father separated. This separation followed a serious domestic assault by her father on her mother for which her father received a suspended prison sentence. During this period her mother spent some time in emergency refuge accommodation with Amy.

5.2 Amy's father moved to another part of the Country and had little contact with either her or her mother. Her mother became aware her father had been arrested but believed it was for offences involving drugs. Her mother was later sent a link to a newspaper report, which indicated the father had been convicted of a sexual offence and received a term of imprisonment. Not long before the father went to prison (November 2015) he started to have limited contact with Amy.

5.3 On his release from prison, Amy's father contacted her mother and asked for contact with Amy, he informed the mother that the contact would have to be supervised. Amy had no contact with her father whilst he was in prison and had not seen him for over 4 years. Her mother recalls being seen by social services but was not informed by any professionals on the exact nature of the offence for which the father had been convicted. The father had given Amy's mother his version of events, which minimised the seriousness of the offence.

5.4 The mother was happy to allow contact as she did not feel there was any risk from the father and it was what Amy wanted at the time, although she feels it was clear that Amy's motivation to have contact with her father was based on money and gifts that he gave her. Both Amy and her mother now recognise this as grooming behaviour by the father.

5.5 Amy's mother states that the father is very manipulative, and she found it difficult to resist his wishes to have contact with Amy. The arrangements for supervised contact with Amy were left for the mother to arrange, which she found difficult as members of her family did not want contact with the father. At the time the father came back into the family, the mother was vulnerable , as a result of discord in her previous relationship. The father was able to exploit this vulnerability by appearing protective and supportive.

5.6 Amy had little recollection of her father in her early life. She was aware that he had been in prison but wasn't aware at the time he was released what he had been in

[1] REACH - Reach is a service for children and young people living in Coventry, aged 5-18, who are experiencing poor mental health, for example low self-esteem, anger or anxiety.

prison for. Amy started to see her father and the contact was supervised and at first there were no issues. Amy cannot recall being asked by any professionals what her feelings or wishes were about seeing him.

5.7 Amy states that her father would spend a lot of money on her and buy her things. This included alcohol and as time progressed to drugs, which included cannabis, cocaine, ketamine and 'pills'.

5.8 Amy's father started to abuse her once he got his own accommodation and their visits no longer had to be supervised (June 2018). No one asked Amy at any time how the relationship with her father was going. Amy knew the abuse was wrong but did not feel confident that she could tell anyone. The father would encourage her not to tell anyone and do his best to make her feel that the abuse was normal.

5.9 Over a period of time Amy would spend more time at her father's address, which was a one-bedroom property. Sometimes she would spend up to three nights per week with him and as lockdown came into place in March 2020, Amy spent several weeks with her father.

5.10 Amy considered herself as vulnerable, she had suffered from low mood, which for her the group sessions with REACH did not address. She was also suffering trauma from the loss of her sibling in 2011.

5.11 When Amy was asked what single thing would have made the biggest difference for her she said '*For people to make more checks and not to close the case. If someone had just checked up on me once a month, that would have helped. There needs to be more precautions*.'

6. Background

6.1 The father was convicted of an offence of sexual activity with a child under 18 years of age in November 2015. The circumstances of the offence were that he had sexual intercourse with a 15-year-old girl who he had known for four years. The victim at the time of the offence had taken cocaine, and the use of drugs were a recognised factor in the offending. He was sentenced to 48 months imprisonment. He was also placed on the Registered Sex Offenders register and a Sexual Harm Protection Order (SHPO) was put in place for an indefinite period. The provisions of this order were to prohibit him from: -

- Living in the same household as any child under the age of 16 unless with the express approval of Social Services for that area.
- Having any unsupervised contact of any kind with any child under the age of 16, other than
  - (i) such is inadvertent and not reasonably avoidable in the course of daily life, or
  - (ii) with the consent of the child's parent or guardian, who has knowledge of his convictions.

6.2 The offence that the father committed, and his conviction, occurred in another part of the Country and therefore he was managed by the NPS for that area. In June 2017, the NPS for that location made contact with the Coventry Multi- Agency Safeguarding Hub (MASH) and informed them the father was due to be released in September of that year and had expressed an interest in having contact with his daughter, Amy.

6.3 The referral requested that Children Services undertake an assessment to establish whether this contact was appropriate and whether the contact should be supervised or unsupervised. The referral identified that the father posed a medium risk of serious harm to female children under the age of 16. It also noted that an assessment was required by Children Services before the NPS was prepared to allow the father to have contact with his daughter (whether this was supervised or unsupervised).

6.4 Within days of the request Amy's mother was seen at home and by Children Services, and potential contact between Amy and the father was discussed. Amy was not spoken to at this stage. At this point Amy had not had contact with her father for the last 4 years.

6.5 In early July 2017, there was contact between Children Services and NPS. The Children Services team manager felt that at the time an assessment was premature, and it was therefore agreed with NPS that a further referral would be made closer to the father's release. Children Services closed the case with the concluding comment '*Mother has been spoken (to) and she has been made aware any contact with the father needs to be supervised given his offence against a child.'*

6.6 In August 2017, NPS records show that they made a further referral to the MASH as requested, 4 weeks prior to the father's release. Children Services have no record of receiving this re-referral and therefore no further action was taken at this stage.

6.7 In September 2017, the father was released from prison. Prior to his release it had been determined that under Multi Agency Public Protection Arrangements (MAPPA) the father was to be managed at Level 1 – Category 1.[2] The father was released on licence with 8 conditions, which included *Not to reside (not even stay one night) in the same household as any female child under the age of 16 without prior approval of your supervising officer and Not to have unsupervised contact with any female children under the age of 16 without the prior approval of your supervising officer and / or Children and Young Peoples Services except where that contact is inadvertent and not reasonably avoidable in the course of lawful daily life.*

6.8 The father was released to a relative's address in Coventry. At this time, he was still being managed by NPS in another area, his management was not transitioned to Coventry NPS until January 2018.

[2] MAPPA Level 1 involves single agency management. Category 1 means that the subject is a Registered Sex Offender (RSO)

6.9 During late 2017 and early 2018, the father made repeated requests to be able to have contact with Amy. There was a concern regarding the father's drug use as this was viewed as a risk factor to his potential re-offending and a variation to his licence was considered. In December 2017, a condition of drugs testing was added due to the father presenting as using drugs and this behaviour being linked to the original offence and therefore a potential risk.

6.10 In April 2018, the NPS offender manager checked with Children Services, who confirmed that the assessment was closed, and that the mother was able to identify a responsible adult to supervise contact with Amy. This presented a view that supervised contact could proceed. At this stage no assessment had taken place.

6.11 In December 2018, the Police and NPS offender managers discussed possible variation to the SHPO around contact with children. This was because the licence condition regarding contact with children and the condition of the SHPO did not fully align.

6.12 In March 2019, The NPS offender manager discovered that the father was seeing Amy in her bedroom to play Xbox. The father was advised this was contrary to his licence condition. The father relied on the condition of the SHPO, which allowed him contact with the permission and knowledge of a parent, in this case the mother. The offender manager reiterated that the contact had to be supervised. The NPS offender manager raised the concern about unsupervised contact with the police and as a result an enquiry was made with Children Services. They were informed the case was closed and a referral should be made through the MASH.

6.13 In April 2019, NPS made a referral to the MASH regarding concerns about the father having unsupervised contact with Amy. As a result, Children Services started a Children and Family assessment in May 2019.

6.14 The assessment was completed at the end of May, after initially being submitted and returned by the team manager for more information it was signed off by a senior practitioner. At the beginning of June 2019, the case was closed with letters sent to the mother and father and the probation service. The assessment concluded that the contact could move to being unsupervised. A notification was also sent to Amy's school. The school were aware of an assessment taking place over contact with the father, but not aware of the circumstances for this assessment or any potential risk that the father may present. The communication with the school was a standard notification which stated that the assessment had concluded and there were no safeguarding concerns. Examination of school safeguarding records also shows that there is no record of the previous trauma Amy experienced over the death of her sibling and discovering this tragic event.

6.15 In June 2019, Amy's school made a referral to CAMHS due to her observed low mood. Amy was accepted for REACH group work that month. This work did not include any one to one work.

6.16 In March 2020, in line with the national Covid lockdown Amy stopped attending school.

6.17 In June 2020, Amy disclosed to her boyfriend that her father had been sexually assaulting her and that this dated back to January 2020. This abuse is said to have started at the point that her father achieved his own accommodation.

7. Analysis of involvement

7.1 To consider how intrafamilial context is used in relation to sexual abuse

7.1.1 The father was risk assessed using the Offender Assessment System (OASys) by NPS and after his release using Active Risk Management Strategy (ARMS) by both police and NPS post his release. These tools mange the risk of re-offending and integration of sex offenders into the community respectively.

7.1.2 Prior to the father's release he was assessed on OASys as posing a medium risk, this is where *there are identifiable indicators of serious harm. The offender has the potential to cause such harm. But they are 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.* This is as opposed to high *where there are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious.*

7.1.3 The OASys risk assessment was undertaken, and the medium risk level assigned whilst the father was still being managed by the NPS in another area and before it was clear that he would have contact with his daughter. The NPS assessor stated *'(the father) is assessed as posing a risk to female children under 16 years of age. Given the circumstances of his offending it is assessed that his risk is greatest to teenage and pubescent female children almost at the age of consent. The behaviour in the index offence suggests that he does not pose a risk to his biological children.'*

7.1.4 The circumstances of the original (index) offence were that the father sexually assaulted a 15-year-old girl who was known to him and where he had been living with the family. Prior to his contact with Amy, her father had limited contact with her for the previous four years. The context of the index offence and the relative lack of relationship with his daughter should have been taken into account when considering what level of risk the father posed to his biological children. It may be if this wider consideration had been given the risk to the biological children would have been assessed as higher. The assessment of medium then had an impact on other assessment activity (fully discussed later in this report). The assertion that the father did not pose a risk to his biological children should have been challenged and the information and evidence used to reach this view tested.

7.1.5 There were opportunities to review the level of risk at later stages when there was a change in factors which could impact on that risk and mitigation required. Examples

of this were - when it became clear that the father was to reside in Coventry, when it was apparent that he was very keen to have contact with his daughter, when it was clear that he was using drugs (a factor in his previous offending) and when he achieved his own accommodation or moved addresses.

7.1.6 The use of drugs by the father is a significant factor and one that causes Amy and her mother a concern. It became known that the father was using drugs, and this was recognised as a risk factor for him due to it featuring in his index offence. The knowledge of the father's drug use resulted in an additional licence condition but did not factor into the risk being re-assessed as far as his contact with Amy was concerned. From discussion with Amy it is apparent that the provision of drugs to his daughter was a means to facilitate his abuse as it had been a feature in his previous offence. Amy feels that had she been provided more information regarding her father's previous offending, and at an earlier stage, she would have been better equipped to identify the similarities in his behaviour. A more robust approach should have been taken regarding the use of drugs, including more regular drugs testing.

7.1.7 There was a strong view within the reflective professional discussion that the distinction between sexual abuse and familial sexual abuse was a false one, in this case when considering risk. The definition of intra familial sexual abuse used by the Childrens Commissioner in a report in 2015 was ' *Child sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member'* [3] There was also a recognition that there was a training requirement for professionals around sexual abuse and in particular how to identify and risk assess the potential for abuse.

7.2 To understand the effectiveness of interagency working in understanding the risk of sexual abuse.

7.2.1 The first referral was made by NPS in June 2017, this was three months before the father's release date. Although Children Services made initial contact with Amy's mother, they advised NPS that it was premature to undertake an assessment and a further referral should be made closer to the release date. The case was closed by a manager with the comment that the mother had been informed that any contact should be supervised. It is not clear how this conclusion is reached without the required assessment. The mother states at this point she had not been fully informed of the nature and full details of the father's offending to allow her to make a fully informed decision.

7.2.2 It is the view of professionals at the reflective discussion event that this referral should have been progressed at this stage, statutory guidance allows up to 45 working days (nine weeks, although Coventry Children Services would seek to

[3] Childrenscommissioner.gov.uk. 2015. [online] Available at: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Protecting-children-from-harm-full-report.pdf>

[Accessed 29 January 2021].

complete this in 30-35 working days) and this would have been timely for the father's release and avoided the confusion which ensued. It is recognised that this referral should have been progressed by the allocated team to a child and family assessment at this stage.

7.2.3 NPS made a further referral to the MASH as requested in August 2017, although Children Services records indicate that this was never received and therefore no further action was taken. When the father continued to request contact with Amy, NPS made an enquiry with Children Services and were informed that the mother was able to nominate a suitable person to supervise contact. At this point supervised contact with Amy was permitted, with no assessment having taken place, Amy and her mother were not fully aware of the risk and the onus for supervision put on the mother. She should have been advised that there should be no contact until an assessment had taken place.

7.2.4 The mother was, at this time, according to her own account vulnerable due to a breakdown in a relationship. Both she and Amy recognise the father as being a very clever and manipulative person who was able to exploit this vulnerability. Unassessed contact, although supervised at this stage, allowed the father to manipulate the situation. Although the father was being managed as an offender there were no measures in place to monitor how the contact was being undertaken and how Amy felt about this increased contact with her father.

7.2.5 A Children and Family assessment was commenced in May 2019, after NPS and police expressed a concern regarding the father having unsupervised contact with Amy. It is recognised that this assessment was superficial. There was limited contact with both Amy and her mother and there was no contact or discussion with the father. There was also a lack of exchange of information between the referrer, NPS and Children Services. There was also a lack of consideration of relevant information from the past, such as domestic abuse in the relationship between Amy's mother and father. The assessment concluded that there could be unsupervised contact, and this was signed off by a senior practitioner and closed by a team manager who was covering. There is a lack of oversight on the closure of the case and it was apparent that the full nature of the index offence and risk was not effectively assessed or considered.

7.2.6 The situation would have benefited from a specialist assessment to determine whether the risk could be managed and how high the risk to Amy actually was. There is now in place within Coventry Children Services the role of *Child Sexual Abuse (CSA) Practice Leads.* This role has been in place for the last year and are positioned within departments to advise practitioners on CSA assessments. Any CSA case would benefit from the input of these leads, who will assist and signpost to specialist assistance if it is required.

7.2.7 At the point of closure Children Services recorded that the mother, the father and NPS were informed of the decision regarding unsupervised contact but NPS records show that they were informed by the father querying the contact arrangements. This

breakdown in communication did not allow any consideration for challenge on the outcome of the assessment.

7.2.8 The lack of a robust assessment and effective oversight resulted in unsupervised contact being allowed. Amy states that she did not feel that any professional sat her down and discussed her wishes. The assessment was not child centred or holistic in the consideration of risk factors. It did not consider the mother's ability and capacity to be protective in light of the history of abuse and coercive control that had existed previously in her relationship with her father.

7.2.9 The national themed Joint Area Targeted Inspection (JTAI) report of February 2020 on Multi Agency Response to child sexual abuse in the family environment[4] conclusion includes '*Too often, risks to all children from perpetrators were not considered. Better training, supervision and support for professionals is needed to address this, as well as implementing the learning from other forms of child exploitation'.* The report also identifies that the support given to children and non-abusing parents is often not consistent.

7.2.10 Within the reflective discussion event it was felt that the determination of the father being a medium risk of harm and the comment that he was not considered a risk to his biological daughter played into the superficial manner in which the assessment was undertaken, whilst it is accepted that this may have had an influence it should not excuse it.

7.2.11 There should have been more inter-agency communication and challenge at the point of the referral, particularly to discuss and understand the risk. It was suggested and accepted that had the father's MAPPA level been determined at Level 2[5] this would have allowed the agencies involved to better assess and understand the level of risk and given a structure in which to work to manage and mitigate that risk. The MAPPA process is not routinely used for all Registered Sex Offenders but would be assessed as being appropriate where routine discussion between agencies could not achieve the required effective management. The MAPPA level is assessed by the offender manager.

7.2.12 Overall there needed to be better communication between the MASH and NPS on referral to fully understand the concerns, and thereafter better communication

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[4] GOV.UK. 2021. *Multi-agency response to child sexual abuse in the family environment: joint targeted area inspections (JTAIs)*. [online] Available at: https://www.gov.uk/government/publications/the-multi-agency-response-to-child-sexual-abuse-in-the-family-environment/multi-agency-response-to-child-sexual-abuse-in-the-family-environment-joint-targeted-area-inspections-jtais

[Accessed 5 March 2021].

[5] MAPPA Level 2 - Cases should be managed at level 2 where the offender: It is assessed as posing a high or very high risk of serious harm, or t**he risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm**, or the case has been previously managed at level 3 but no longer meets the criteria for level 3, or **Multi-agency management adds value to the lead agency's management of the risk of serious harm posed.**

between NPS, the police and Children Services to fully understand and assess the risk, using all available information. It would assist NPS and MASH to have a clear expectation on timing and processing of referrals for persons being released from prison who pose a risk to children. This could include a discussion around the suitability of MAPPA intervention.

7.2.13 At the time of the father's conviction he was made the subject of an indefinite SHPO. On his release from custody there were a number of licence conditions put in place. It is important that those conditions and that of the SHPO are complimentary. The licence condition stated no unsupervised contact with any child under 16 without approval of NPS supervising officer or Children Services, whilst the SHPO prohibited contact with a child under 16 unless with the consent of the child's parent or guardian, who has knowledge of his convictions. This anomaly allows the offender to manipulate the conditions as Amy's father sought to do, although the offender manager was resolute. Had the case been a level 2 MAPPA, issues such as these could have been discussed and managed.

7.3 To be assured that the child has an informed voice and that this is captured and informs the assessment.

What was the impact of Covid 19 what additional support do young people need to disclose sexual abuse?

7.3.1 Discussion with Amy for this review found her to be a very open young person who was able to talk about her experiences in the hope that it would assist professionals to prevent what happened to her occurring to other young people.

7.3.2 During the first referral for assessment Amy was not spoken to. During the assessment in 2019 Amy was spoken to once on her own and once in the presence of her mother. Amy has a limited recollection of this conversation but does not recall her views on contact with her father being sought or information regarding his previous sexual offending being openly discussed. The assessment did not focus on the trauma caused to Amy by the death of her sibling and the fact that she had discovered her sibling. This continued to impact on Amy and her needs for support focusing on this was absent. This added to Amy's vulnerability. The fact that the school was not aware of this also impacted on the support that might have been available.

7.3.3 There is evidence that the school were aware and conscious of Amy's feelings as they referred her to CAHMS after she was observed demonstrating a low mood at school. When this was explored with Amy, she stated that she was able to disclose this to a trusted teacher. She did not feel that she would have been able to disclose the abuse in the same way as it was important to her that she was able to tell someone who knew her father as this would assist in their understanding.

7.3.4 Further exploration of what factors presented the opportunity for Amy to tell others what was happening to her revealed that Amy disclosed to her boyfriend who she trusted. She had previously been in what she described as a toxic relationship

and her current relationship had allowed her to reflect on what a loving relationship should be and understand how wrong her father's abuse to her was.

7.3.5 Another factor in Amy telling others when she did was her desire to protect her siblings. Her father was becoming more ensconced within the family unit and Amy was very uncomfortable with this in the knowledge of the manipulation and abuse he was capable of.

7.3.6 The lock down restrictions started in March 2020, Amy's last day at school was 20th March. The offending against Amy started in January 2020. Whilst the offending started before the lockdown period, the Covid lockdown had an impact on the continuing abuse and the ability for Amy to disclose what was happening to her.

7.3.7 The lockdown meant that Amy was spending extended periods at her father's address, which was a single room accommodation. This added to her isolation and the ability for Amy's father to continue his offending.

7.3.8 The wider implications of the Covid pandemic are recognised in the Government Strategy on Sexual Abuse launched in January 2021[6]. There continues to be a great deal of recent activity focusing on Child Sexual Abuse. The Centre of Expertise on CSA is delivering a capacity building programme and the Independent Inquiry into Child Sexual Abuse continues investigation into key areas.

7.3.9 The Coventry Children Safeguarding Partnership launched their own Sexual Abuse Strategy 2021-2023 with the following aim ' *To ensure that partners work together to prevent child sexual abuse and to provide timely and appropriate intervention, from early help to statutory intervention, to those children and young people requiring protection and support from child sexual abuse.'* The findings of this review should be used to build on the actions emanating from this strategy. Many of the facets of this case chime with the proposed actions within the prevent, protect and support strands of the strategy.

7.4 To consider practitioners assessment of parent/carers ability to protect where there is coercion or control.

7.4.1 In the past Amy's father had been the perpetrator of domestic abuse on her mother. This undoubtedly impacted on the mother's ability to make uninfluenced decisions. Her mother states that she was not able at the time to resist her father's requests for more contact with Amy. Amy's mother states that she was manipulated by the father, he did not use force or threats but was able to ingratiate himself into the family by offering her support at a time she was vulnerable.

7.4.2 The main contact with the father was by the NPS offender manager whilst he was on licence and thereafter the police offender manager as the father continued as a

[6] Assets.publishing.service.gov.uk. 2021. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/955493/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

[Accessed 5 March 2021].

Registered Sex Offender. The father was very keen to establish a relationship with his daughter and it is not evident that his motivation for this contact was really explored or challenged. It was recognised by probation and police offender managers that they could have been more challenging of one another regarding the risk that the father posed to his own children.

7.4.3 The position where the onus for arranging safe and supervised contact was left with the mother was far from ideal. Her options were limited to family, many of whom did not want any contact with the father themselves due to the domestic abuse he had perpetrated on the mother. What supervised contact actually meant was never discussed with the mother, did it mean in the same room, in the same house? Too much of this important area lacked structure and was left to interpretation. There needed to be much clearer boundaries and support for the family if this contact was to be considered.

8. Learning from this case

- There needs to more awareness for professionals on Child Sexual Abuse. The differentiation between familial and non-familial sexual abuse is false and a distinction should not be drawn between them when considering risk.
- Practitioners need to be more professionally and appropriately challenging of assertions regarding risk. This challenge and curious approach should be ongoing and reviewed at relevant milestones and changes in circumstances.
- Where an offender transitions from one area to another the receiving area should ensure that there is an up to date risk assessment, which reflects any new information and changes in circumstances.
- Where an assessment is required as part of a prison licence condition for child contact it is imperative that it is robust, child centred and holistic. That it considers the history of the case and involves all agencies with involvement. Specialist input into the assessment should be considered. It should also consider the vulnerability of the child and adverse experiences that impact on that vulnerability.
- An appropriate 'vehicle' for multi-agency offender and risk management where contact with children is concerned is MAPPA. In this case, management at level 2 MAPPA would have allowed for a structured multi agency approach and continued discussion to facilitate coordinated and timely risk management.
- All agencies need to be aware of the manipulative nature of sex offenders and that they will seek to manipulate victims, families and professionals alike.
- When considering contact issues with families it is important that they are given the full information of the offending including risk factors, such as the use of drugs. This will allow them to make informed decisions.
- Where risk factors are identified such as the use of drugs, risk assessments should identify this and measures put in place to mitigate and better understand the risk, such as regular drug testing and monitoring.

- Where supervised contact is permitted all parties should be absolutely clear as to what supervised means. There also needs to be an exploration as to whether the supervision is sustainable.
- Police Offender Managers should use notifications for change of address of Registered Sex Offenders to review what contact they are having with young children and young persons and how that contact is being undertaken.
- Where contact with a Registered Sex Offender is supervised or unsupervised there should be regular welfare checks with the children or young person to ensure that they remain central to the situation and every opportunity is given for any concerns to be raised by them.

9. Recommendations

1. The Coventry Safeguarding Children Partnership should use this review to build on and promote the recently released partnership Sexual Abuse Strategy 2021-23.

2. The Coventry Safeguarding Children Partnership should review with relevant partners how child contact with Registered Sex Offenders is assessed and dealt with. This should include:

- A clear and agreed understanding of when a referral for assessment of a Registered Sex Offender requesting contact should be made and how that should be progressed.
- That assessments are child centred and holistic, that there is good oversight and that there are ongoing safeguarding measures built in for children and young people.
- Consideration of the use and greater awareness of the MAPPA framework
- Joint understanding of how risk assessment is undertaken within different agencies.
- That children, young persons and families are provided with full information to allow them to make informed decisions regarding the risk.
- That supervised contact is defined so that it is clear to all concerned what the expectation is.
- How the information can be shared with other professionals who have an active role in the child's life and need to be sighted on the risk.

3. Coventry Children Services should further promote the role of Child Sexual Abuse Lead Professional.

4. Where a Registered Sex Offender is the subject of prison licence conditions and a Sexual Harm Prevention Order that the National Probation Service and West Midlands Police work together to ensure that the conditions are complimentary and where necessary the condition of pre-existing orders are reviewed.

5. The National Probation Service promotes the briefing of staff in accordance with Effective Practice briefing on Intra-familial Child Sex Abuse.

6. The Coventry Safeguarding Children Partnership should review how information is shared with schools which will assist them when safeguarding and monitoring the wellbeing of students. This information will also be important when schools need to undertake vulnerability assessments for periods when children and young people may not be in school.

Appendix A – Terms of Reference

1. Introduction

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learned and services improved to reduce the risk of future harm to children.

Amy is 15 years old, and on 18th June 2020 Children's Service received a referral from the Police as Amy had disclosed that she has been sexually abused by her father on multiple occasions.

Amy's father is on the sex offenders register.

Amy and her father were having unsupervised contact following a previous assessment in 2019 completed by Coventry Children's Services, in conjunction with Probation, which supported this.

On this basis, a Local Safeguarding Practice Review has been commissioned to consider this case.

2. Scope of the review

Subject: Amy

Time period under review:

From: 1st June 2017
To: 18th June 2020

Any relevant background information prior to this time period to be included in the review as considered necessary.

Timescale for SCR completion: Coventry Safeguarding Partnership should aim for completion of an LSPR within six months of initiating it. If this is not possible, every effort should be made while the LSPR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

Agreeing improvement action:

Coventry Safeguarding Partnership should oversee the process of agreeing with partners what action they need to take in light of the LSPR findings.

Publication of reports: All reviews of cases meeting the LSPR criteria should result in a report which is published and readily accessible on the Board's website for a minimum of 12 months. The final published report should be submitted to the NSPCC National case repository. This is important to support national sharing of lessons learnt and good practice

in writing and publishing LSPRs. From the very start of the LSPR the fact that the report will be published should be taken into consideration. LSPR overview reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

Meetings with Family/Significant Others

- Coventry Safeguarding Partnership will write to the family to notify them of the review. This will be sent Recorded Delivery to ensure it goes to the correct address and to confirm it has been received by family members or personally served.
- Opportunities will be offered to the parents to participate in the process, subject to other processes.
- It is hoped that the family will be visited by the Lead Reviewer as soon as possible to gain an understanding of any learning they can provide to the review.
- A further meeting will be undertaken prior to publication to share the learning with the family.

3. Agency contributions

Initial scoping and information requested from;

- South Warwickshire Foundation Trust
- Children Services
- National Probation Service
- University Hospital Coventry Warwickshire
- West Midlands Police
- Coventry Warwickshire Partnership Trust
- Education
- Amicus Health Surgery
- Woodend Health Centre
- Henley Green Medical Centre

4. Specific terms of reference and lines of enquiry

A chronology will be formulated from information gathered from the rapid review. Agencies may be contacted and asked to expand any information that is identified as relevant from the merged chronology.

Practitioners will be invited to a reflective discussion event where identified themes will be discussed to identify areas of learning and development and areas of good practice.

The rapid review has identified the following key areas of consideration.

- To consider how intrafamilial context is used to assess risk in relation to sexual abuse.
- To understand the effectiveness of interagency working in understanding the risk of sexual abuse.

- To be assured that the child has an informed voice and that this is captured and informs the assessment.
- The impact of COVID19 and additional support that young people may need to disclose.
- To consider practitioners assessment of a parent/ carers ability to protect where there is coercion or control.

Appendix B – About the author

The author in this review is Jonathan Chapman, he has no prior involvement with the case and is not connected to any of the agencies involved. He is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer. He has undertaken serious case reviews, safeguarding adult reviews, MAPPA case reviews and domestic homicide reviews, with various boards across the Country. He has also worked with Clinical Commissioning Groups, The Church of England and the third sector on safeguarding matters.