

Local Child Safeguarding Practice Review

Children B and C

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1. BACKGROUND

1.1 The purpose and underpinning principles for undertaking reviews of children's circumstances are set out in the statutory guidance "Working Together to Safeguard Children 2023." This review takes a systemic approach in its examination of the key lines of enquiry including highlighting good practice; using B and C's circumstances as a lens through which to consider wider safeguarding practice undertaken in Blackpool.

1.2 The Children Act 2024 as amended by the Children and Social Work Act 2017 gives responsibility for how a system learns lessons from serious child safeguarding incidents to the three Safeguarding Partners (clinical commissioning groups (now integrated care systems), police and local authorities). This particular review will use the circumstances of B and C to review the multi-agency response to identifying and sharing information held about a family's history by agencies across different geographical boundaries and identifying and managing the risk of child sexual abuse outside of the family home and identify improvements to the safeguarding system accordingly.

1.3. This independently led Local Child Safeguarding Practice Review¹ (LCSPR) is concerned with two young children of White British heritage who lived with their mother and father. They are referred to as B and C, and the parents by their relationship to the children throughout the report. The alleged perpetrator is referred to as Male A. For reasons of confidentiality no further identifying details will be provided within the review.

1.4. B and C had two older half-siblings and three older siblings who were removed from the care of their mother and father due to concerns of physical abuse and neglect in another local authority outside of the North West area (LA 1), several years prior to their birth. B and C were aged 4 and 2 respectively when B made an allegation that indicated he had been sexually abused by an adult male who was a friend of his parents. Subsequent enquiries established that the adult male was a prolific registered sex offender who had been released from prison under strict licence conditions.

1.5. The Blackpool Local Safeguarding Children Multi-Agency Safeguarding Arrangements (MASA) agreed that the children's circumstances met the criteria for a LCSPR as set out in the statutory guidance². The review takes a proportionate approach to exploring the periods during the mother's pregnancies with B and C. The review will primarily focus on evaluating practice during the period from April 2022 to September 2023 which encompasses the management of a life registered sex offender outside of the family home and the investigation into the allegations of sexual abuse, and also considers the timeframe during the mother's pregnancy with B and C.

¹ Child Practice Reviews are the arrangements for undertaking multi-agency reviews involving a significant incident where abuse or neglect of a child is known or suspected.

² Working Together To Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. December 2023. HM Government.

1.6. B was described by the professionals who supported him as “bouncy” and chatty. He liked helping people and was thoughtful, funny and kind. C was less chatty due to his speech and language delays. B and C were very loving towards each other and enjoyed being praised.

2. METHODOLOGY

2.1. An Independent lead reviewer was appointed to lead the review.³ The methodology adopted for this LCSPR was a hybrid system approach with a focus on evaluating the practice response to the children and their family, identifying strengths of practice and areas for improvement in order to improve the multi-agency response to safeguarding and promoting the welfare of children in Blackpool.

2.2. The Review Team⁴ had access to the key single and multi-agency documents and met with practitioners involved with the family in reflective sessions where the children’s circumstances and the practice response was discussed.

2.3. This approach is consistent with the purpose of LCSPRs as outlined in “Working Together to Safeguard Children 2023.” The predisposing risks and vulnerabilities⁵ that were known at the time were considered, in order to understand the children's story. This was followed by the consideration of the preventative and protective actions taken. The agencies that had involvement reflected on the agency specific learning and shared learning within their agencies.

2.4. The parents of B and C were invited to contribute their views and experiences of working with agencies in order to understand what worked well and what improvements could be made to the safeguarding system. Unfortunately they were unable to contribute at this time.

2.5. The views of the alleged perpetrator Male A were obtained in relation to the offender management system and these are included in the report.

2.6. Drafts of this report were shared with those involved to ensure collaboration and ownership and to provide scrutiny and challenge. The recommendations were written by the Lead Reviewer and the Review Team. The report was signed off by the three Designated Safeguarding Partners (DSP’s) and presented to the MASA Board.

2.7. This report has been written in the anticipation that it will be disseminated for learning to the members of the Blackpool Children Safeguarding Multi-Agency Safeguarding Arrangement and contains only the information that is relevant to the learning established during this review.

2.8. A robust action plan has been developed by partners to address the learning and

³ Jenny Butlin is an experienced independent social work consultant who is independent of the partnership.

⁴ The Review Team was composed of senior leaders from the agencies who supported B and C and their family.

⁵ Complexity and Challenge: a triennial analysis of SCRs 2014-17.

recommendations in the report and the progress of this will be reported through the governance of the partnership.

3. NARRATIVE CHRONOLOGY OF PROFESSIONAL INVOLVEMENT AND FAMILY BACKGROUND.

3.1. In 2017, the parents moved from another Local Authority area outside of the North West (LA 1) to Blackpool. Whilst living in LA 1 they had four children removed from their care due to concerns about neglect and physical abuse of the fourth baby when they were about one week old. They received custodial sentences for child cruelty and later had a fifth baby whose gestation and birth was concealed from agencies. That child was removed from their care when this was discovered.

3.1. In May 2018, the mother attended the early pregnancy unit in Blackpool and the scan showed a viable pregnancy (with B). She advised that she had one older child who lived with her and the baby's father. This information was false. By this time the mother had had 5 older children who had been removed from her care.

3.2. In June 2018, the mother attended an ante-natal booking with the midwife and she reiterated the information above and in response to questions, confirmed that she had not received support under child protection nor services from statutory agencies. This was again, false information.

3.3. In December 2018, B was born.

3.4. In January 2019, B was seen by the Health Visitor at a new birth visit. He was seen in the presence of his mother, maternal grandmother and a child who was described as his elder sister. This information was also false.

3.5. Around April 2019, B began attending a childminder's for five days per week as his mother had returned to work and his father was also working.

3.6. In June 2020, the mother attended an antenatal appointment in respect of her pregnancy with C. She confirmed that she had had two previous pregnancies and had no previous support from statutory agencies which was again untrue.

3.7. In December 2020, baby C was born.

3.8. In April 2020, B began attending the childminder with C as his mother had returned to work and his father was also working.

3.9. In April 2022, Male A was released from prison after a 13 year sentence for sexual offences with children under the age of 16, on strict life licence conditions to an approved premises in a neighbouring council area for a 12 week period after which time he would move to Blackpool. The level of contact with the probation officer was to be face-to-face each week for a month and then a minimum of monthly thereafter, with face-to-face being more frequent.

3.10. That same month, the probation officer for Male A made a referral to Adult Social Care for an assessment of his care and support needs due to his ill-health.

3.11. In August 2022, Male A was placed at a Bed and Breakfast establishment.

3.12. The same month, Male A had a polygraph test which showed no significant response.

3.13. From September 2022, Male A was seen by his probation officer and much of the discussion focused on accommodation.

3.14. In December 2022, Male A moved to a flat which was approved by the offender manager.

3.15. In January 2023, the childminder advised the mother to clarify that B's skin condition was just eczema as it was bothering him.

3.16. In February 2023, Male A had a second polygraph test which showed no significant response.

3.17. In March 2023, the childminder made a referral to Speech and Language Therapy (SALT) as she had completed a Wellcomm assessment with B and was concerned that he mainly used non-verbal communication.

3.18. The same month, the police made a referral to children's social care as C was seen in the local community unsupervised in his nappy and there were also concerns regarding the home conditions. Children's Social Care visited the family and noted that the house was cluttered but not unacceptable. Enquiries were made with health services and the childminder. The parents did not want any help and the record was closed.

3.19. The following month, the police made a referral to children's social care following a call-out to a domestic incident. The parents said that the call had been made by one of the children in error. The house was noted to have rubbish in it and dirty nappies were strewn across the floor. One of the children was noted to have a skin condition. The mother was contacted by a social worker and she advised that they were on holiday.

3.20. Later that month, Male A was downgraded to a medium risk. He had been out of custody for 12 months and was believed to be complying with his licence conditions, with two polygraphs completed without any concerns.

3.21. In May 2023, a statutory social work assessment of the children and family commenced as the family had now returned from a holiday abroad and consequently the family accepted the offer of support under section 17 of the Children Act 1989⁶ under a Child in Need plan.

⁶ General duty of every local authority to safeguard and promote the welfare of children in their area, promote the upbringing of such children by their parents by providing a range and level of services appropriate to those children's needs. Children Act 1989.

3.22. That same month, the Offender Manager visited Male A. It was noted that he had made friends with staff at a local venue that did Karaoke and at a theatre and found it easy to make friends. It was noted that there was no evidence that he was on a pathway to offending but that he will always present a risk to children.

3.23. In June 2023, a social worker visited the parents. They stated that they had not had any previous social care involvement. When they were challenged about this being untrue, the parents said that they had had two children adopted and had moved to Blackpool in 2016 and were now different people. Home conditions were reported to be adequate.

3.24. The following week, a social worker contacted LA 1 and formally requested a copy of the full records.

3.25. In July 2023, a Child in Need meeting⁷ was held online but the parents did not attend as they said they had difficulties with the technology. The parents were spoken to after the meeting and a plan of support was discussed.

3.26. In September 2023, B started to attend primary school and C started to attend nursery which were part of the same educational establishment.

3.27. In mid-September, C was noted by the nursery to have bruising to his ear. This was discussed with C's mother who said he had climbed on a table and fallen. C's father was also spoken to and he said he didn't know how it had happened.

3.28. In late September 2023, B told a member of school staff that his mummy and daddy were "bad" and when asked why, he said that the house was messy, that his mother had bottles in her room and rubbish bags everywhere. B later said that someone else had cleaned up the mess but the name of the person was unclear.

3.29. The following day, a Child in Need meeting was held online but the parents did not attend. Blackpool Children's Services had received the full bundle of information from LA 1 and key documents were read and a summary shared in the meeting.

3.30 Staff members at the nursery noted that C's behaviour had deteriorated and he was hitting other children.

3.31. In early October 2023, the parents attended parents' evening. A teacher asked the parents who was looking after the children and they avoided giving an answer. When B was asked about this the next day he said 'X' (Male A).

3.32. Two days later, the nursery advised the social worker that C was displaying sexualised

⁷ A Child in Need meeting is led by the child's social worker together with other professionals supporting the child and family and is attended by the parents (and the child where appropriate to their age and understanding) and reviews the progress of the plan of work.

behaviour towards staff, peers and using dolls. The nursery officer contacted C's mother who said that he may have witnessed her and his father having sex whilst he was in his cot. Advice was provided.

3.33. On the same day, the social worker spoke to the mother about C's sexualised behaviour and during the conversation requested details of Male A. The mother said she had met Male A through work and had known him for 12 months. C's mother stated that she did not know Male A's full name, address or DOB and was requested to provide these as soon as possible and not to allow unsupervised contact with unknown adults. This was followed up by the social worker three days later and the children's mother stated that she had not been able to get them yet.

3.34. A few days later, B told the designated safeguarding lead at school that Male A did exercises with him and demonstrated thrusting his hips backwards and forwards. This was reported to the social worker who advised them to refer this to the police and she said she was going to visit the family. There was no evidence at that time that parents were aware of Male A's history.

3.35. Later that day the social worker and the police officer spoke to the parents and details were provided for Male A, who was subsequently arrested. The children remained in the care of their parents.

3.36. A strategy meeting was held which decided that s.47 enquiries⁸ would be undertaken and legal advice was to be sought. Concerns were raised by a health professional that the children had remained in the care of their parents and they requested that this was escalated to managers for further consideration. Consequently, the children were removed from their parents' care under the police powers of protection later that day and the children became cared for by the local authority.

4. DETAILED ANALYSIS.

4.1. How well did the safeguarding system support the understanding of the children's needs and their parents' capacity to meet them?

4.1.1. The review found that the safeguarding system was not fully effective in enabling professionals who supported the family to understand the children's needs and the parents' capacity to meet them.

4.1.2. In March 2023 the police made a referral to children's services which was concerned with neglect of C due to lack of supervision and poor home conditions. Although the parents' previous criminal convictions for neglect in 2008 were recorded by the police within the referral and it was flagged as high risk by the police, it was not flagged as high risk by children's services and was

⁸ The Local Authority's duty to investigate to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

instead sent to the Early Help MASH. (This is explored further in 4.3).

A home visit was undertaken by a practitioner two days later to determine the extent of the poor home conditions and they found the home conditions to be cluttered but not unacceptable. The disparity between the view of the police and the Early Help worker was likely to be due to the improvements the parents made since the time of the referral. The lack of supervision to C was discussed and bolts were put on the doors. The parents were offered Early Help support but declined this and therefore no further action was taken.

4.1.3. Following a second referral by the police the following month, a statutory social work assessment appropriately commenced. By this time, the social work service was aware that non-recent social work intervention had been provided to the parents' older children by LA 1 due to concerns regarding neglect, physical abuse and historical sexual abuse by the father to his sister when he was a child, which led to the children being removed. However the full details were still awaited from LA 1. The assessment included information from relevant professionals including the GP, health visitor and child minder. However, the health information was ineffective because the historical information was not known and therefore could not inform the assessment. (This is explored further in 4.3).

Consequently, it was identified that support was required under Section 17 of the Children Act 1989 to which the parents agreed. The review found that the social workers felt that without all the relevant information, support under a Child in Need plan was appropriate and proportionate as there had been no concerns raised about the care provided to these children prior to the recent referrals. This appeared to influence the practice examined throughout the scoping period.

4.1.4. Despite the previous concerns of neglect of the older siblings, there was not a clear understanding of the neglect that the children experienced. The completion of the partnership's neglect tool, Graded Care Profile 2 (GCP2) had commenced as part of the Child in Need plan but had not yet been concluded during the scoping period. The review learned that at the time, the GCP2 was not widely used. However, the safeguarding partnership has now updated the neglect strategy and refreshed GCP2 the training for assessment of neglect and has monthly training sessions scheduled in 2025 to support practitioners in the identification and assessment of neglect. (Recommendation 1).

4.1.5. In September 2023, the social worker received information from LA 1 about their previous involvement with the parents which indicated that the children were at risk of significant harm. This was an opportunity to consider convening a strategy discussion but this was not taken because there was already a Child in Need plan in place which was being progressed and was felt to be proportionate to the current situation as there had been no reported concerns about these children prior to the referral in March 2023. However, this did not sufficiently take into account the now known risks posed to the children and this was a missed opportunity to explore this

further. This type of “anchoring bias”⁹ causes people to rely too heavily on the first piece of information they receive- the anchor- in this case, that the children had been well cared for, for several years without concern- and therefore the level of concern was viewed as relatively low. As a result of discussions undertaken during this review, the social work service recognises that a strategy meeting should have been convened.

4.1.6. The review considered how well Male A was known and understood by the services working with him. Male A was a prolific sexual offender who had been subject to Imprisonment for Public Protection (IPP) which gives an indeterminate sentence and release from custody can only be granted by the parole board. Male A had some physical health needs and a psychological report prepared whilst he was in custody stated that he had traits indicative of autism although he did not have a formal diagnosis. The review found that he exhibited highly manipulative behaviour which masked his vulnerability to re-offending. He was regularly seen by his probation officer and MOSOVO¹⁰ who maintained appropriate professional curiosity. Whilst they often challenged him, he was highly manipulative and provided appropriate responses to questions. He was adamant that he was not sexually attracted to children and would not place himself in situations whereby he was at risk of re-offending.

4.1.7. In April 2023 a risk assessment was undertaken of Male A by the probation officer, and he was downgraded from a high risk of harm to a medium risk because he had been released from custody for 12 months without any concerns arising and he had also had two polygraph tests which did not indicate any concerns about his behaviour. The review found that his history of offending, which indicated that he would pose a high risk of re-offending, had not been sufficiently taken into account. As a result of being downgraded to a medium risk of sexual offending, the mandatory requirement for him to have polygraph tests ended. The practitioners advised that they had not been aware of this at the time and had they been, this would have influenced their decision. This learning has now been shared with the local probation team. However, it should be noted that the second polygraph test did not identify that Male A was lying (as at this time it was likely that he was visiting the children and their parents at home) and therefore polygraph tests should not be solely relied upon as set out in the policy framework.

4.1.8. Learning points.

The completion of the GCP2 would have provided a clearer understanding of the neglect that the children experienced.

- When new information is received, the Social Care Team should always ensure that the pathway and process to safeguard and meet the needs of the children is appropriate and

⁹ Practice guide. Bias in child protection decision making. Department of Families, Seniors, Disability Services and Child Safety April 2025. <https://cspm.csyw.qld.gov.au/getattachment/dd453153-6025-4cb3-a2d5-e8af32c4df8d/PG-Bias-in-child-protection-decision-making.pdf>

¹⁰ “The Sexual or Violent Offender Manager is specially trained in the response to and Management of Sexual or Violent Offenders (MOSOVO.)” The College of Policing website.

proportionate. When the information indicates that the threshold of risk of significant harm may be met, a strategy discussion should be undertaken.

- When undertaking a risk assessment of a sex offender, it should be taken into account that when a sex offender is downgraded from a high to medium risk, mandatory polygraph tests are no longer required which may reduce the understanding of an offender's risk.

4.2. How well did the safeguarding system enable the children's voices to be heard?

4.2.1. The review found that the children's voices were sought and listened to during the scoping period of the review and in most instances, professionals responded appropriately. Both B and C were vulnerable due to their young ages and they were reliant upon their parents to meet their needs. They both had developmental delays and their speech was limited which meant that they found it difficult to verbally convey their experiences to adults. The children were regularly seen by the childminder and later by staff in the education settings. They were reported to be well dressed and clean and their presentation did not raise any concerns and this provided assurance that the children's basic needs for appropriate clothing and hygiene were being met. The children were seen regularly at home by the social workers, usually by prior appointment and on some occasions on unannounced visits and this provided a helpful understanding of the children's experiences of being cared for. The children regularly attended nursery and school and had a good relationship with staff members who were attuned to their needs.

4.2.2. Shortly after C started nursery school, the staff became concerned about his aggressive behaviour towards his peers and notably sexualised behaviour towards staff, peers and dolls. C's sexualised behaviour was discussed with the parents who said that he may have witnessed them having sex as he came into their room sometimes. This was concerning. A safety plan was discussed which included C not coming into the parent's bedroom at night and not leaving the children with anyone they didn't know or trust. However, his aggressive behaviour was not explored further. It is likely that C's behaviour was a means for him to communicate what he was witnessing and/or experiencing and provided professionals with the opportunity to explore this further, particularly in light of the previous concerns. A strategy discussion was not considered because this concern was considered in isolation and did not take into account the current concerns of neglect and concerns about their parenting of their older children. This was a missed opportunity to consider C's voice further.

4.2.3. In late September 2023, B told a member of school staff that his mummy and daddy were "bad" and when asked why, he said that the house was messy, that his mother had bottles in her room and rubbish bags everywhere. This was likely to have been distressing for B. B later said that someone else had cleaned up the mess but the name of the person was unclear. This information provided insight from B's perspective about a deterioration in the home conditions and that there was someone unknown to him who came to the house. Importantly, this provided insight into his

lived experiences. This was queried with the mother several days later when an unknown male was mentioned again, but denied. This demonstrated that his voice was heard. The review heard that the conditions of the home were regularly checked and support was provided to sustain improvements.

4.2.4. The identification of child sexual abuse is often challenging for professionals because there is an over-reliance in the safeguarding system of children disclosing the abuse to a trusted adult who can help them, rather than the wider system being able to identify the signs of sexual abuse and taking a co-ordinated approach to prevent the harm from taking place and/or to safeguarding the child. The report by the Child Safeguarding Practice Review Panel “I wanted them all to notice”¹¹ highlighted this issue; “Overwhelmingly, practitioners are relying on children to verbally report their abuse before taking action, which has implications for pre-verbal and non-verbal children. Furthermore, children are not being given opportunities to communicate what is happening to them.” In recognition of these challenges, the Blackpool MASA is part of the North West Tackling Sexual Abuse Strategy, a regional initiative focused on preventing and responding to sexual abuse and violence as part of a broader national effort to address child sexual abuse and sexual violence. (Recommendation 2).

4.2.5. Members of nursery and school staff were concerned about B and C and were tenacious in their efforts to identify who else was caring for the children, other than their parents. The Designated Safeguarding Lead (DSL)¹² spent time with B and encouraged him to talk about how he felt. This undoubtedly enabled B to feel safe and to be heard and he went on to disclose information that indicated he had been sexually abused by a man, later identified as a registered sex offender (Male A). This was good practice by the DSL and the school staff which prevented B and C from experiencing further harm.

4.2.6. Learning points.

- Children’s behaviour should be seen as a form of communication and concerning behaviour should invoke further exploration by professionals.
- The good practice by the DSL enabled B to feel safe and supported his disclosure.

4.3. How effective was the safeguarding system in supporting communication within agencies and between agencies to safeguard B and C?

4.3.1. The review found that the safeguarding system did not support effective communication consistently within and between agencies to safeguard B and C. This was partly because the

¹¹ Child Safeguarding Practice Review Panel “I wanted them all to notice” November 2024. www.gov.uk/government/publication

¹²A Designated Safeguarding Lead (DSL) in a school is a senior member of staff with the primary responsibility for safeguarding and child protection (including online safety) within the educational setting.

mechanisms for professionals to access non-recent information were not sufficiently robust and enabled the partial and false information provided by parents to take precedence.

4.3.2. Communication within and between agencies takes place verbally between professionals and in the form of records held by organisations and is complex. Effective communication is dependent upon the different agencies in the safeguarding system identifying the significance of information that they hold and sharing them in ways that will be easily and quickly understood. Poor or inconsistent communication is a common theme in child safeguarding practice reviews and is also highlighted by this review.

4.3.3. When the mother's pregnancy with B was confirmed by the midwifery service at the hospital, she provided false information about her earlier pregnancies when asked and only confirmed one previous pregnancy and birth, probably because that child had been delivered by caesarean section and recognised that her caesarean scar would be identified. The review learned that there is no requirement or expectation that the information provided by a mother is verified unless there is reason to do so. The NICE guideline Ante-natal care recommendations¹³ state "Consider reviewing the woman's previous medical records if needed, including records held by other healthcare providers". The sole reliance on a mother's account by midwifery services means that there is a risk that possible earlier pregnancies and safeguarding concerns are not known. In this case there was no reason for the midwife to be concerned about the pregnancy and therefore verification of the mother's information was not sought. In Blackpool, if any concerns are highlighted at any point during the pregnancy, the midwife refers the mother to the Complex Social Needs midwifery team (CSN) which completes a thorough review and develops a safeguarding plan including external agencies where required. It is of note that whilst in Blackpool, midwives are able to access GP records (and therefore they could be viewed to verify information provided by a mother if needed), this arrangement is not in place between all midwifery services and GP practices in England.

4.3.4. The review learned that the online registration forms for GP practices provided by NHS England do not include a facility for a patient to provide information about previous social care involvement with their children, only current involvement. Including this facility on the online registration form would provide the opportunity for professionals to be aware of previous social care support and consider exploring this further. Whilst this was not relevant to this family as the parents were not registering their children, it may be helpful for NHSE to consider this further.

4.3.5. The GP practice in Blackpool was not aware of the mother's previous pregnancies and births because there had been a delay in the mother's paper GP records being transferred from the previous GP practice in another ICB area (ICB 1). The responsibility for the transfer of paper records is managed by a nationally commissioned agency and there are no statutory or recommended timescales for the transfer of G.P. paper records. Although the electronic records were transferred promptly, these contained more recent health information whereas the paper

¹³ Ante natal care Nice guideline NG201 published 19 August 2021 <https://www.nice.org.uk/guidance/ng201>

records contained historical information which related to the mother's previous pregnancies and births. There was no mechanism in place by the GP practice to check whether the electronic records which had been received were complete and whether there were paper records that needed to be transferred. Similarly, there was no mechanism in place to check whether the paper records had been transferred to the practice, and this was not identified until this review, some six years after the mother moved to the GP practice. The review learned that the GP practice now has mechanisms in place to check whether paper records have been received as a result of learning from this review. In light of the national relevance of this learning, this will be communicated to NHSE for their consideration.

4.3.6. The review subsequently learned that the mother's GP records from LA 1 did not include any reference to the social care involvement that had been in place. This is learning for ICB 1 and further exploration should be undertaken by the ICB to understand how widespread this issue is.

4.3.7. The health visiting service was not aware of the previous concerns about the parents' care of the older children and this limited their understanding of the risks posed to B and C. Following B's birth, the mother was not asked by the health visitor about any previous involvement by children's services because this was not included on the form used by the health visiting service. As a result of this learning, the health trust has now included this question on the system for all universal health visitor contacts, including transfer in and antenatal and this enables the opportunity for a dialogue about any previous interventions. It should be noted however, that the effectiveness of this relies on a mother being truthful and in this case, it was likely that the mother would not have been.

4.3.8. Health visiting services were provided for both children. Whilst most home visits were conducted by the named health visitor, other clinical appointments were managed by several different health professionals. The review considered how well communication between the different health clinicians in the health visiting service works and the impact on the understanding of a child's needs when children are seen by different practitioners at a clinic. The review learned that they work collaboratively as a team and are able to access the health visiting records of children who present at clinics which would include information about whether they were receiving a social work service. This provides assurance to the partnership that appropriate safeguards are in place.

4.3.9. In March 2023, the police made a referral via telephone and this did not reference the parents' criminal convictions for child neglect. The following day, the police followed up the call with a police safeguarding referral which did include the information about the parents' criminal convictions. However, because the referral was already open and being screened for information held by partners, the convictions were not added onto the internal system in error. As a consequence, although the referral was flagged as a high risk vulnerability by the police it was not by children's social care and was instead sent to the Early Help MASH team. The review learned that these were individual errors and the learning has been shared with the teams.

4.3.10. When social care undertook the assessment after the second referral, information was appropriately sought from the childminder, but they were not informed of the outcome of the assessment and subsequently that there was a Child in Need plan in place. This was a missed opportunity for the childminder to have increased awareness of the children's needs and to contribute to the plan for the children, particularly given that she saw them and the parents regularly. The review team learned that childminders are not always viewed as childcare professionals and therefore may not be afforded the same status as others such as nursery practitioners. This influenced the lack of information sharing with the childminder and children's social care recognise that this needs to be addressed. (Recommendation 3).

4.3.11. The communication systems between children's services in LA 1 and Blackpool were not effective in sharing information. Unlike health records, social care records remain the responsibility of the council or Children's Trust which provided the service, and it is therefore possible for several different councils and/or Trusts to hold social care information about the same child and family if they have lived in several geographical areas. When the referrals to children's social care were made by the police, some information was provided by children's social care from LA 1 and fuller information was requested in June 2023. This was escalated in July 2023 to a senior manager in children's social care and also to legal services who requested the court papers prepared for the care proceedings of the older children. This information was not received until September 2023. The delay in receiving information meant that the social worker and the other professionals were not aware of the full severity of the concerns and the significant risks posed to the children. There are no statutory or recommended timescales for information to be transferred between different geographical children's services, and this enabled an environment where parents could deceive professionals. In light of the national relevance of this learning, this will be communicated to the Department for Education for their consideration. The review team considered the challenges in escalating concerns between children's services in different geographical areas when personnel are not known and children's social care recognised that work needed to be undertaken to develop a clear escalation process. (Recommendation 4).

4.3.12. The review learned that in this case, strategy discussions were not consistently convened when the threshold was met, and this led to missed opportunities to share information amongst professionals and consider whether further enquiries needed to be made.

4.3.13. In early September 2023, shortly after C commenced nursery school, several bruises were noted to his ear to which the parents provided different explanations to the nursery and the social worker. Accidental bruising to ears is very unusual and should have been thoroughly investigated and this was not recognised by children's social care at the time. The review team explored this more fully and health colleagues helpfully advised that as a result of this learning, they have proactively provided learning materials for health staff who come into contact with children to support the understanding of why bruising to a child's ear is concerning and the steps to be taken to investigate this further and this is reinforced through quality walk rounds throughout the health trust. Children's Social Care has included this learning in continuous improvement activities.

4.3.14. In light of the bruising and the inconsistent explanations, it would have been appropriate to have considered whether to convene a strategy discussion to share information and consider whether further action needed to be taken. The statutory guidance states: “Whenever there is **reasonable cause to suspect** that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children’s social care (including the residential or fostering service, if the child is looked-after), the police, health and other bodies such as the referring agency.” This would have enabled further exploration of the concerns and a social worker from LA 1 could also have been invited to attend which would have provided the opportunity to learn more about their involvement and the detail of the concerns.

4.3.15. In September 2023, C’s nursery became concerned about his aggressive behaviour towards peers and sexualised behaviour towards staff, peers and dolls. C’s sexualised behaviour was discussed with the parents who said that C may have seen them having sex as he sometimes comes into their room at night. The review learned that a strategy discussion was not convened because there was no evidence of where the behaviour had originated from. This was a misinterpretation of the statutory guidance as a strategy discussion should be convened “Whenever there is **reasonable cause to suspect** that a child is suffering or is likely to suffer significant harm” rather than evidence of this.

4.3.16. As outlined in 4.1.6, in September 2023, CSC received information from LA 1 which indicated that the children were at risk of significant harm and therefore a strategy discussion should have been considered. The review team found that the pervading belief the child in need plan was proportional to the current situation as there had been no reported concerns about these children prior to the referral in March 2023, preventing the professionals from understanding the significance of the historical information.

4.3.17. In light of the findings, the review considered how widespread this issue was. The review learned that quantitative and qualitative data and findings from audits have not found that this is a systemic issue in the Blackpool area. Notably, the Joint Area Inspection of the multi-agency response to identification of initial need and risk in Blackpool undertaken in November 2024¹⁴ found that “When there are concerns about children being at risk of significant harm, effective multi-agency strategy meetings lead to thorough child protection enquiries which identify the impact of the risks and the child’s needs when the threshold is met.” The review also learned that children’s social care regularly undertakes quality assurance activities which provide assurance that strategy discussions are convened appropriately. However, as it was a finding in this review, the review team felt that additional assurance should be provided to the partnership. (Recommendation 4).

4.3.18. The review found that communication between the social worker and members of nursery and school staff was regular and this enabled a shared understanding of the concerns as they

¹⁴ <https://files.ofsted.gov.uk/v1/file/50268027>

emerged

4.3.19. In October 2023, B's school informed the social worker of B's disclosure. Due to the children being shortly due to leave school and nursery, the social worker, the police and the school appropriately took immediate action to safeguard the children. The social worker advised the teacher to inform the police and went to visit the parents, with a police officer joining later. This led to information about Male A being provided and he was subsequently arrested. The review learned however, that the discussions held were not recorded as a strategy discussion which meant that the plan to investigate the concerns and safeguard the children was not clearly recorded in line with local and statutory expectations. A strategy discussion which included health partners was held the following day. (Recommendation 4).

4.3.20. The review learned that when Male A was placed in the approved premises after his release from prison, the children's services in the local authority area in which he was placed were notified by the prison in accordance with the national policy. However, when Male A moved to accommodation in the Blackpool area, children's services were not notified because there was no underpinning policy to do so and therefore they were not aware that he was in the area. Due to the national relevance of this learning, this has been communicated to the National Policy Lead for Probation for further consideration and action. (Recommendation 5).

4.3.21. Learning points:

- The reliance by midwifery services on a mother's sole account of previous pregnancies and births, without checking the mother's G.P records, risks previous safeguarding concerns being missed.
- The absence of statutory timescales for the receipt of the mother's GP paper records and the lack of a system to identify that they had not been received enabled a significant delay in these being received by the G.P in the Blackpool area and meant that the information about the mother's previous pregnancies and births was not known.
- The absence of statutory timescales for social work information to be shared between local authorities and the lack of robust escalation by Blackpool contributed to a significant delay in information being shared by LA 1.
- Strategy discussions should be recorded in all instances.
- Regular communication between the members of staff at the education settings and the social worker enabled a shared understanding of the emerging concerns.
- Domestic abuse and safeguarding information is requested for all people managed by the Probation Service. Where there are safeguarding concerns in respect of an identified child the Probation Service would submit a safeguarding referral, but there should be consideration of a mechanism for informing the Local Authority of a person posing a risk to children living in the local area.

4.4. How effectively did the safeguarding system support the professionals to consistently engage the adults?

4.4.1. The review explored the ways in which the professionals sought to engage the parents in working with them and found that there was learning to take forward. Throughout the period of time examined during the review, the parents provided incomplete and false information to professionals about non-recent and current events. This made it very difficult for the professionals to gain a clear picture of the family's previous experiences and current situation.

4.4.2. Many LCSPRs have highlighted the issue of "disguised compliance"¹⁵ and this was a feature of this review. On the surface, the parents often presented as engaged with professionals and services. The mother attended the midwifery service throughout her pregnancies with B and C and the children were brought to relevant health appointments, they attended the childminder and later nursery and school and presented well. This was likely to have falsely reassured the professionals.

4.4.3. Following the first referral to children's social care, the parents were offered an early help service which they declined. Whilst there is no requirement for parents to accept early help support, parents should always be encouraged and supported to participate in early help provision where a need has been identified, to prevent the need for more intensive support at a later time.

4.4.4. Once a social work service was provided, children's social care held regular multi-agency Child in Need meetings to review the progress of the plan to support the family. These meetings were held online rather than face-to-face. The review learned that this practice had developed during the Covid-19 pandemic to meet the government's requirements for social restrictions and had continued as it supported the attendance of professionals who no longer had to travel to meetings. This approach is common to many local authorities however, in this case, the review learned that the parents did not attend; citing technological difficulties. These reasons were not explored more fully to understand whether there were technological difficulties or whether this was a sign of the parent's lack of engagement and other alternatives considered. This impacted on the social workers' abilities to build a relationship with the parents and create an environment where there was a clear understanding of their engagement and strategies implemented to address any barriers to this. Whilst online meetings may be helpful in facilitating attendance by professionals, their suitability for all families should be considered as families may feel unsupported without professionals in the room and they may create an environment in which families can avoid professionals, which was likely to be the case for this family. The review learned that online meetings are no longer used routinely and the majority of meetings which include parents/carers are held face-to-face.

4.4.5. None of the professionals involved were aware of Male A's involvement with the family and it later became apparent that the mother was evasive about providing information about him

¹⁵ "Disguised compliance involves parents and carers appearing to cooperate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993). This can mean that social workers and other practitioners may be unaware of what is happening in a child's life and the risks they face may be unknown to local authorities." NSPCC website. Reder, P., Duncan, S. and Gray, M. (1993) Beyond blame: child abuse tragedies revisited. London: Routledge.

when this was asked of her. Importantly, the lack of fuller engagement by professionals with the parents impacted on the effectiveness of the interventions provided.

4.4.6. An article by Vince Peart¹⁶ explored the reasons why a parent might provide false information which can include; “Fear of judgement or repercussions....protecting oneself or others.... previously negative experiences of professionals” and need to be understood in order to work effectively with parents. The review found that there was learning in relation to implementing strategies to try to engage and support the parents as outlined in Peart’s work including; establishing trust and rapport, enhancing professionals’ self-awareness and emotional intelligence, utilising relevant assessment tools such as the Adverse Childhood Experiences questionnaire and self-esteem scale.

4.4.7. In this case, whilst a strengths-based approach was adopted, in the absence of the non-recent information, the positive elements of the parents’ care of the children were likely to have falsely reassured the professionals and reduced the understanding of the risks posed to the children. Once the information was received from LA 1 in September 2023, the extent of the false information provided by the parents was apparent but this did not lead the professionals to consider ways in which to engage the parents more fully to enhance professionals’ ability to work with them. The review learned that the MASA is undertaking a piece of work to develop the skills of the partnership in working with parents who can be seen as difficult to engage which will include training. (Recommendation 6).

4.4.8. The review also explored the way in which agencies sought to engage Male A. Male A presented as being engaged with his probation officer and MOSOVO compliant with the conditions of his licence. It was only following B’s disclosure that his deception of professionals became known.

4.4.9. The probation officer and the MOSOVO worked hard to engage Male A and he presented as well engaged and compliant. Prior to his release he had successfully completed rigorous sex offender treatment programmes. Following his release, Male A was seen regularly at his home address at unannounced visits and at the office and the risks he posed were regularly discussed with him. Male A also engaged with two polygraph tests, neither of which raised any concerns and his (basic) mobile phone was regularly viewed so that his contacts were overseen. Male A was subject to strict licence conditions which on the surface, he appeared to adhere to.

4.4.10. Male A told his probation officer about the friendships he had formed with people in the community but in discussion with the reviewer, he was unable to account for why he had not mentioned his friendship with the boys’ mother. Male A informed the review that he felt his probation officer engaged him well but he had not felt able to inform them when he had first met

¹⁶ “How to deal with people who lie to Social Workers.” Social Work News- 03 May 2023. By Vince Peart.

the boys because he knew this was a breach of his sex offender harm prevention order and he would be recalled to prison.

4.4.11. Learning points.

- The appropriateness of the use of online meetings with parents should take into consideration the nature of the concerns/interventions and the likely impact on professionals' engagement with parents.
- When information comes to light that a parent has deliberately provided false or incomplete information, consideration should be given to exploring this further in order to build a more trusting relationship and to ensure that the children are appropriately safeguarded.
- It is important to challenge information provided by adults to test its truthfulness, particularly where there are concerns about transparency.

4.5. How effective was the child safeguarding system and offender management system in enabling interventions by agencies to safeguard B and C?

4.5.1. The review found that the safeguarding system and offender management systems were not consistently effective in enabling the interventions to safeguard B and C.

4.5.2. The child in need plan addressed the concerns relating to the home conditions and there were improvements noted. However, it was not amended to address the concerns about the parents' care of the older children as these emerged. Information from LA 1 about the older children's concerning histories was received in September 2023 and this indicated that B and C were at risk of significant harm. By this time, there were also additional concerns about the bruising to C's ear and C's aggressive behaviour towards peers at nursery. Although this information was shared with the other professionals at a Child in Need meeting, it did not prompt consideration of whether further enquiries needed to be made and whether support was being provided at the right level; for example, should support be provided under a child protection plan or should legal advice be sought with a view to initiating care proceedings? This anchoring bias (explored in section 4.1.6) prevented the professionals from reviewing what they understood about the parents' care of the children and influenced future decision making.

4.5.3. Both the social worker and the designated safeguarding lead (DSL)¹⁷ from B's school felt that there was more going on in the household than the parents were sharing. Consequently, members of school staff became much more attuned to the boys' needs and took particular care and

¹⁷ A designated safeguarding lead (DSL) is a person in a school or college who is responsible for child protection and safeguarding.

interest in them. This provided them with safety. An example of this was when both parents attended B's parents evening and the teacher asked the mother who was looking after the children. The mother's evasiveness raised the suspicions of the teachers who pursued this with B. School was undoubtedly a safe environment for B and it is likely that this later enabled him to make an allegation that he had been sexually abused by Male A. This was good practice by the school.

4.5.4. Following B's disclosure to the DSL, the social worker and a police officer visited the children and the parents at home and Male A was arrested. This enabled the children to be safeguarded from the risk of further harm from him. However, the children remained with their parents because it was believed that the only risk was from Male A. The review found that the child protection investigation undertaken that evening only focused on Male A and did not consider the role of the parents' neglectful parenting in enabling the harm to take place. The review explored with the practitioners the different forms of neglect as identified in J. Horwath's work¹⁸ including; "Lack of supervision and guidance – this involves a failure to provide an adequate level of guidance and supervision to ensure a child is physically safe and protected from harm. It may involve leaving a child to cope alone, abandoning them or leaving them with inappropriate carers." Although the children were removed by the police the following day, this left B's account of the alleged abuse vulnerable to being influenced by his parents. Children's social care have reflected upon this and recognise that this was not appropriate. This learning has been included in ongoing improvement work.

4.5.5. The following day a strategy discussion was held which shared the information about the allegation and Male A's arrest. A health professional from the 0-19 service challenged the decision made for the children to remain in the care of their parents as they recognised that the parents had been neglectful. The challenge was supported by the other professionals and appropriately accepted by children's social care. Subsequently the police used their powers of protection and removed the children. This was good practice by the health professional and enabled the children to be safeguarded. This also demonstrates that the use of challenge by safeguarding partners is effective.

4.5.6. The review found that although the practice of the probation service and the MOSOVO was undertaken in accordance with policies and procedures, it was not effective in reducing Male A's risk of re-offending because Male A deliberately sought to deceive professionals about his activities.

4.5.7. Prior to his release in April 2022, Male A completed several rigorous sex offender programmes including group and individual sessions with a psychologist and his release was approved by the parole board with strict licence conditions attached. His (basic) mobile phone was regularly seen and the contact numbers checked.

¹⁸ Horwath, J (2007) *Child Neglect: Identification and Assessment*, Basingstoke, Hampshire: Palgrave Macmillan

4.5.8. In discussion between the reviewer and Male A, he advised that he had felt well equipped to be released from custody and was determined to make a fresh start. He described in detail the work he completed in the sex offender programmes and the way in which they had positively influenced his thinking. He was able to recall in detail non-contentious events but struggled to recall events that portrayed him in a negative light, which indicated that he was being untruthful and attempting to mislead the review. It was evident that Male A is a highly manipulative person who went to considerable lengths to conceal his relationship with the children and the parents and disguised his compliance with his licence conditions.

4.5.9. Male A said that he met the children's mother at her place of work. He denied that he was aware that she had children and only discovered this when she invited him to her home in April 2023. He said that he did not know what he could say to the mother in order to leave (although this would have been discussed in the sex offending treatment programmes). Male A often provided information which was contradictory for example, he said that he wanted to keep himself to himself but then spoke of people's generosity towards him and his popularity with others, which indicated that he was in fact active in the community and he described incidents which portrayed him in a good light and could have been followed up to check for the accuracy of his information. Whilst these contradictions provided the opportunity for more rigorous challenge, he was deliberately deceiving professionals and it is unlikely that his contact with the children would have been identified earlier.

4.5.10. Learning points.

- Members of school staff were attuned to B's needs and created a safe environment for him which supported his disclosure.
- Inadequate supervision of children, including children being cared for by people not well known to their parents, should be seen as a form of neglect and responded to accordingly.
- The safeguarding system was effective in responding to appropriate challenges.
- Reinforcing strategies learnt on the sex offender treatment programme may help to reduce the risk of an offender being in contact with children.

5. SUMMARY

This review identified some good practice and several areas for improved practice for the safeguarding system in Blackpool. A robust action plan has been developed by partners to address the learning and recommendations in the report and the progress of this will be reported through the governance of the partnership.

The areas for national learning detailed in 4.3.5, 4.3.11 and 4.3.21 will be communicated to the relevant government departments and the Child Safeguarding Practice Review Panel.

6. RECOMMENDATIONS

In light of the learning the following recommendations are made:

Recommendation 1

The safeguarding partnership should seek assurance that:

- There is a clear training plan for relevant professionals in GCP2.
- The GCP2 is used in assessments of children where neglect is a feature.
- Professionals feel knowledgeable and confident when using it.

Recommendation 2

The safeguarding partnership should ensure that the regional work to improve the identification and response to child sexual abuse informs training, learning and development programmes and policies and procedures in this area of practice.

Recommendation 3

The safeguarding partnership should:

- Seek assurance from children's social care that agencies and solo professionals such as child minders who contribute to statutory assessments are informed of the outcome.
- Ensure that this learning is included in multi-agency training.

Recommendation 4

The safeguarding partnership should seek assurance from children's social care that:

- Escalation processes are developed to enable issues of concern, including those related to the actions of another local authority, to be resolved promptly.
- Strategy discussions are convened where there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm and that they are recorded as strategy discussions in all instances including where they take place with only one partner agency in an urgent situation for example out of hours.

Recommendation 5

The safeguarding partnership should seek assurance from the Probation service that the National

Policy Lead for Probation has been asked to consider the inclusion in guidance that notifications about the movement of registered sex offenders who present a risk to children are provided to the local authority where the offender is currently located.

Recommendation 6

The safeguarding partnership should review the safeguarding training available to practitioners to ensure that practitioners are suitably skilled to respond to adults who provide false or partial information to professionals.