Cheshire East Safeguarding Children's Partnership

Local Child Safeguarding Practice Review

Re Child L

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Contents

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1. Introduction and context for the review

1.1 This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Cheshire East Safeguarding Children Partnership (CESCP) to consider the multi-agency safeguarding response around child sexual exploitation[2] and intra-familial harm regarding a 13-year-old girl known as Child L. This recognised a number of contributing factors and responses where lessons could be learned about the way agencies worked together individually and collectively to respond and safeguard children.

1.2 Child L aged 13 made a disclosure of rape in 2022, the perpetrator was a known sexual offender. At the time of the incident, Child L was subject to an Interim Supervision Order and a Child Protection Plan. She had previously made three allegations of rape and sexual assault outside of the home. She was at high risk of exclusion from school due to her behaviour and attendance (although outside the scope of this review plans to move her to an Alternative Educational Placement[3] started at the end of Year 9 and she was permanently excluded in October 2022 just three months later and within weeks of starting the new educational placement) There were reports of missing, involvement in antisocial behaviours including fire setting, cannabis, and alcohol use. Child L reported feeling worried in the community and there were instances of self-harm. There was a significant history and involvement from adult and children's services throughout Child L's life. Child L reported physical abuse within the home from mother's partner. Police involvement with the family was significant concerning issues of domestic abuse, substance misuse, violence, and criminality.

1.3 Alongside this review the police in collaboration with probation have undertaken a separate review of the management of sexual offenders, The lead reviewer has discussed the actions relating to this case with the Detective Chief Inspector with responsibility for Offender Management. There is clear evidence of significant improvements to systems, processes, and training regarding the management of sexual offenders with improvements to monitoring offenders' behaviours and use of Vulnerable People Assessment(notifications) known as VPA to children's services. This involves weekly management oversight within the offender management service and a programme of audit and peer review. Whilst this does not address specific issues relating to grooming or specific intelligence relating to child sexual exploitation, newly established Child Exploitation teams led by the police across the partnership area will support wider contextual issues relating to extra familial harm.

[2] Child Sexual Exploitation is 'a form of child sexual abuse where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.' Child sexual exploitation: definition and guide for practitioners - GOV.UK (www.gov.uk)

[3] Alternative Provision (AP)is defined as education provision outside school arranged by the local authorities or schools themselves . Its full time and can be for young people because they are excluded , are unwell or otherwise suitable education. would not receive

1.4 The timeframe for the practice review includes the period of national lockdown between March 2020 and March 2021. This is significant for Child L as it occurred at a critical developmental stage(adolescence) and was a period where there would have been a reduction of many of the normal protective services. Research shows vulnerability to exploitation increased during this period when young people were isolated from their usual support networks it also saw an increase in online activity, all features prevalent in this review.[4] Thematic analysis of Rapid reviews by the Child Safeguarding Practice Review Panel highlighted the situational risks of COVID-19 on vulnerable children and families where "the potential to exacerbate pre-existing safeguarding risks and bring new ones"[5] was a factor in their findings.

1.5 Cheshire East underwent a Joint Targeted Area Inspection (JTAI) with the theme of child criminal exploitation (CCE) [6] in July 2022, this corresponded with practice in the same time frame of this review. Key learning is being addressed through a comprehensive partnership action plan, this will be cross-referenced where appropriate particularly in relation to learning and recommendations This is an important contextual consideration in relation to systems and practice at the time. Improvements are evidenced through the JTAI Improvement Plan over the past 14 months, this is now completed with practice improvements and system changes now forming core practice across the Partnership.

1.6 The rapid review highlighted a number of improvements that could be made to improve safeguarding systems and practice across the partnership. This review does not intend to repeat these, and single agency improvement actions are already in place, but consider systems and practice from a learning perspective as they apply in this review and can be used to provide ongoing assurance for the partnership in relation to intra and extra-familial harm in relation to sexual and physical abuse.

[4] NSPCC Isolated and Struggling 2020 - https://learning.nspcc.org.uk/research-resources/2020/social-isolation-risk-child-abuse-during-and-after-coronavirus-pandemic

[5] The Child Safeguarding Practice Review Panel Webinar January 2021 Thematic analysis of rapid reviews featuring Covid -19

[6] There is no legal definition of CCE The Children's *society states whilst it takes many forms "ultimately it is the grooming and exploitation of children into criminal activity. Across each form that CCE takes, the current reality is that children who are coerced into criminal activity are often treated as criminals by statutory agencies rather than as victims of exploitation. This is in part because safeguarding partners have different understandings of what constitutes criminal exploitation. Recently, CCE has become strongly associated with one specific model known as county lines" https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines*

1.7 **Summary Learning**

Learning is detailed and analysed throughout the report and key points are summarised here

- ✓ The importance of appreciating the child's lived experience and the cumulative impact of adversity, harm, and trauma.
- ✓ Children and young people who make disclosures of abuse and harm must be listened to with intent to do something and consider other behavioural responses to harm. Children should not be blamed for their own exploitation.
- ✓ The significance of sharing information through a multi-agency lens. The importance of critical reflection and challenge
- ✓ Develop systems and practice that are domestic abuse aware and trauma-informed,
- ✓ The importance of identifying a trusted adult with vulnerable young people and building relationships. Recognising the safety that school can provide for children experiencing intra and extra-familial harm
- ✓ Increased awareness of the signs of child sexual exploitation and the processes to access specialist guidance/support
- ✓ Ensuring disclosures of harm have a statutory multi-agency response and include consideration of health and wellbeing needs.
- ✓ Developing a whole family /think family response to support understanding of risk where there are complex adult issues.
- ✓ Recognising the importance of critical thinking through good reflective supervision

2 Review methodology

2.1 It was agreed that the review would be undertaken using the SILP (Significant Incident Learning Process) methodology, which engages frontline staff and their managers who were involved with the child(ren) and the family. It seeks to avoid hindsight bias or individual blame and encourages critical thinking to focus on the *why* and opportunities for improvement. Engagement with children and family is a key part of the process.

2.2 The rapid review[7] identified initial key lines of enquiry (below) and this LCSPR (Local Child Safeguarding Practice Review) has built on this to develop additional learning for the partnership. The rapid review posed a number of questions, and these were used to support reflection and

[7] A rapid review is undertaken in order to ascertain whether a Local Safeguarding Practice Review is appropriate or whether the case may rise issues which are complex or of national importance and if a national review may be appropriate.

actions in the Single Agency Reports[8] and informed the multi-agency face-to-face practitioner event. Engagement in the learning process has been positive demonstrating a real openness to learning and supported understanding of the key issues. Initial learning from the rapid review was summarised into the following areas:

1. Understanding and measuring the impact of intervention
2. Process, drift, delay, and escalations
3. Pathways to interventions in relation to Child Sexual Exploitation (CSE)
4. Childs voice and disclosures of harm
5. Parental substance misuse and domestic abuse
6. Assessment and managing risk in relation to extra familial harm, exploitation, and the management of sex offenders.

2.3 This formed the starting point for this LCSPR and enabled reflective discussion in the learning event around four key aspects, this supports understanding of how professionals responded to needs, vulnerabilities, and risks in respect of Child L and why.

Key Practice Themes
The child's lived experience
Multi-agency responses to risk and harm
Understanding of CSE and management of risk
Parental issues

2.4 The scoping period for the review covered the two-year period up to the reporting of the rape from December 2019 to March 2022. Child L has been known to services since her birth and relevant historical information has been analysed and included in the summary below.

2.5 Attempts to engage with the significant adults in her life have not been successful. Child L agreed to meet and talk to the lead reviewer at the end of the review process, her voice is shared and identified within the report. It is important not only to hear her but to ensure we learn from her experiences, the lack of trust in professionals remains an overwhelming feature of her narrative and is palpable in meeting her.

3 Relevant backgrounds prior to the scoped period

3.1 Child L from age two lived at home with her mother, mother's partner and two younger half-siblings to her mother's partner, she had spent short periods living with family members leading up

[8] Agency reports are completed where agencies have the opportunity to consider and analyse their practice and consider any systemic issues. They provide details of the learning from the case within their agency. Then practitioners, managers and agency safeguarding leads come together for a learning event.

to the incident. There were reports of domestic abuse between her mother and her birth father. Mother's partner has an extensive criminal history including charges for drug and violent offences including a prison sentence for battery. Mother is also known to police for drug, alcohol, and violent offences as well as being a victim of domestic abuse from both of her partners.

3.2 There were twelve referrals into children's social care in the first 10 years of Child L's life, these related to concerns about parental substance misuse, domestic abuse, and a physical injury to Child L. This included three assessments however all these referrals ended in no further action by children's social care. This showed limited understanding of the cumulative harm for these children which increased their vulnerability and risks of harm.[9] In September 2017, following disclosures the younger siblings made to school that mother's partner had hit their mother and taken her keys, Children Services became involved. A Strategy Meeting and Section 47 investigation followed, and the matter progressed to an Initial Child Protection Conference (ICPC). The multi-agency meeting decided it did not meet the threshold for significant harm and a period of Child in Need[10] intervention followed before the case was closed.

3.3 Within two years of the above incident a further reported domestic abuse incident led to the children being subject to a Protection Plan under the category of emotional harm. The children were present when mother's partner had taken their mother by the neck, pushed her and tried to pull her out of the front door. Child L and her half-siblings remained subject to a Child Protection Plan for the period of this review. This occurred in December 2019 and forms the starting point for this LCSPR.

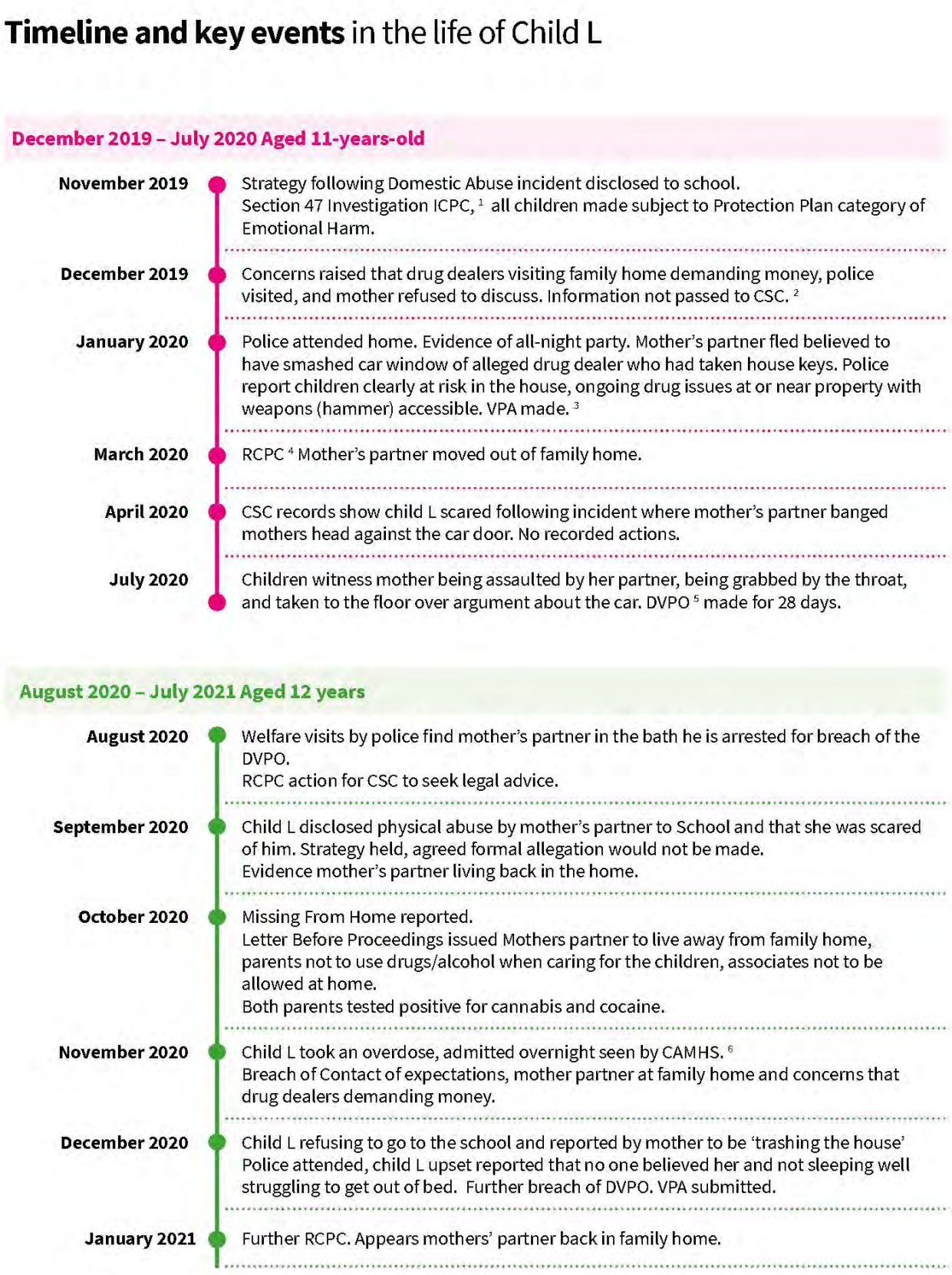
3.4 Whilst this LCSPR is focussed on Child L it is important to acknowledge that the two younger siblings have experienced and been impacted by the same family dysfunction, parenting and harm around domestic abuse and lifestyle associated with drugs and criminality. As events escalated with Child L the family narrative appeared to be that things were more settled without Child L in the family home, and she was seen as 'the problem.'

[9] Complexity and challenge ;a Triennial analysis of SCR 2014- 17 Brandon, Sidebotham et al https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

[10] Child in need is the general duty on local authorities to safeguard and promote the welfare of children in need in the area, Section 17 of the 1989 Children Act.

4 Timeline of key events

The following timeline is a helpful tool to illustrate critical events in Child L's life during the scoping period for the review by compiling high-level and significant information to support understanding of what life was like for Child Land the family.



August 2020 – July 2021 Aged 12 years ...continued

April 2021
Child L attended A&E cuts to wrist and expressing suicidal thoughts.

May 2021
Report that child L had received indecent images on her phone.
School attendance for younger children deteriorating.

June 2021
Child L took overdose at school, admitted to hospital overnight seen by CAMHS.
Same day Mother's partner requested help to move out of family home.

July 2021
Mother asked for help with child L's behaviour, reported missing. Child L shared mother's partners had assaulted her and she did not want to go home.
Agreed she could stay with her grandparents.
Strategy held; mothers partner interviewed under Caution. ABE interview [7] held.
No further action taken regarding the assault.

August 2021 – February 2022 Aged 13 years

August 2021
Child L sharing photos of how-to self-harm online.
Escalation of mother and partners drug use.
Child L disclosed she was coerced into having oral sex with male 16 years.
Strategy and Section 47 commenced, she declined to undertake an ABE interview.

September 2021
Child L took a further overdose admitted to hospital and seen by CAMHS.
Attendance 24%. 1 day fixed exclusion.

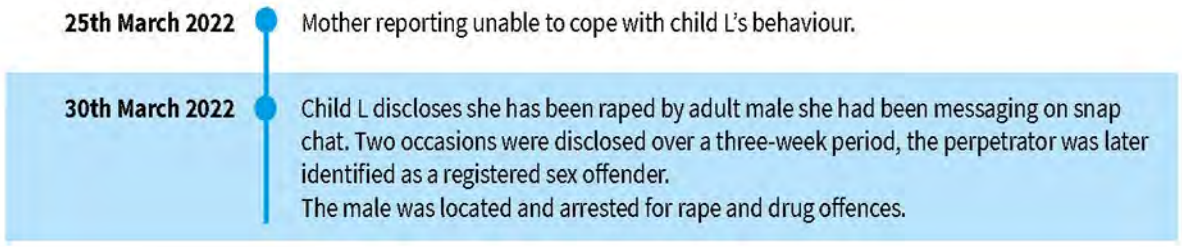
October 2021
Reports of child L's involvement in anti-social behaviour and fire setting.
Child L is missing for three consecutive nights covering the above incidents.
A community Resolution order is made.
Child L taken to hospital after consuming drugs and made disclosure of being sexually assaulted by two elder males. She was taken to the SARC [8].
Police complete Child Sexual Exploitation Screening Tool.
Further disclosures that mother's partner assaulted, mother would not agree to her partner moving out, so she stayed with grandparents.
Child L goes missing from Grandmothers in the night. Once found by mothers' partners, she was found to have been corresponding with unknown male including sharing indecent images.
Child L barely attends school from this point. At risk of exclusion.

November 2021
Legal advice sought.
Child L reported missing and located in Manchester.
CSC notes that Child L smoking cannabis.
Further missing episode.

December 2021
Child L goes to live with family member for a few weeks.
She returns home and family do not cope well.

January 2022
Senior management decision to initiate legal proceedings to request a Supervision Order RCPC .
Missing episode Child L intoxicated, and reporting had been raped, very distressed evident bruising saying, 'we won't do anything anyway.' No medical undertaken.

February 2022
Child L shared with the school nurse that sexual activity is not always consensual.
Shared with mother and social worker Outcome not known.
28th February Interim Supervision Orders made.



1 Initial Child Protection Conference
2 Childrens Social Care
3 Childrens Social Care
4 Review Child Protection Conference
5 Domestic Violence Protection Order
6 Child Adolescent Mental Health Services
7 Achieving Best Evidence
8 Sexual Assault Referral Centre

5. Thematic analysis and identification of Key learning

5.1 The child's lived experience – how the partnership understood vulnerability and harm.

5.1 There is evidence of many attempts by the multi-agency team to engage the family in work to address the adult issues and work with child L, parenting (Webster Stratton[11])including intensive family support and 1:1 work for Child Land support from the wider family network was sought. There were some periods of short-term change for example around the time of pre-proceedings when intensive support was in place, but this was not sustained. Practitioners report this coincided with the period when Child L was living out of the family home. Whilst identified changes in social workers impacted the coordination and progression of interventions there was simply too much happening in this family for the adults to engage in any meaningful way. There was limited analysis of cumulative harm caused by multiple significant events and adverse experiences meaning the impact and the risks to Child L were not fully understood and evaluated. Child L as reflected on by the Independent Reviewing Service was a child at risk of significant harm for an extensive period.

5.2 The Pathways to Harm, Pathways to Protection framework developed in the Triennial Analysis of Serious Case Reviews[12] is relevant here and can be used as a conceptual model to help professionals understand the '*pathway to harm'* experienced by Child L systemically by considering the context, vulnerabilities, risk, and harm against areas for prevention and protection provided by parents/carers, and agencies.

[11] Evidence based parent training programme known as the Incredible Years Parent Training
[12] Figure 2 Pathways to harm , pathways to protection
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

5.3 It is evident from the history that Child L experienced a number of adverse childhood experiences[13] from birth that will have contributed to her vulnerability and the trauma she experienced. The practitioner group reflected on her home life and reflected on the situation where there were arguments and violence, parents under the influence of and needing drugs, and strangers coming to the door and described that the curtains were often closed leaving the house dark. Routines and boundaries were reported to be unpredictable; school attendance before the lockdown was around 50% including many lates. The school was reported to be a safe place where she felt able to talk openly about her home life and is the place, she has made significant disclosures. This had a bearing on her feelings of safety when she was subsequently missing from school and at risk of exclusion. Grandmother and an aunt provided periods of respite and care at some critical moments. Home as described by the practitioners and by the history of the case was not a safe place.

5.4 The learning event captured how some staff felt scared on home visits specifically in relation to mother's partners' behaviours presenting under the influence of substances and being volatile. The home was seen as one of 'constant conflict.' When the children were not at school during lockdown measures this was said to have increased with Child L seemingly 'scapegoated' within the family. At this time there was phone contact from the school and statutory social work doorstep visits in line with reduced service delivery due to Covid measures. This was a difficult period for many young people such as Child L and will have increased stresses and vulnerabilities within the household. [14]

> *"In many cases parents were hostile to helping agencies and workers were often frightened to visit family homes. These circumstances could have a paralysing effect on practitioners, hampering their ability to reflect , make judgements, act clearly and to follow through with referrals assessments and plans. Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents made it difficult for professionals to see children or engineered to focus away from allegations of harm , children went unseen and unheard" Brandon et al 2008.*

5.5 Of significance at the learning event was information that Child L discovered her mother's partner was not her birth father, he had been in her life from the age of about two and practitioners reported her upset and confusion about discovering this, she was said to have made

[13] Adverse Childhood Experience (ACEs) Current definition includes as experiences which require significant adaptation by the developing child in terms of psychological, social, and neurodevelopmental systems, and which are outside of the normal expected environment (adapted from (McLaughlin, 2016). ACEs may include other adversities not included in Felitti et al.'s 1998 study, such as bullying victimisation, parental death, and community violence. https://www.acamh.org/topic/aces/

[14] NSPCC Isolated and Struggling 2020 - https://learning.nspcc.org.uk/research-resources/2020/social-isolation-risk-child-abuse-during-and-after-coronavirus-pandemic

attempts to connect with her birth father unsuccessfully in this period. Practitioners felt this had a significant impact on her emotional well-being as she tried unsuccessfully to meet with him. The impact of this was shared with the lead reviewer directly by Child L who described her feelings of being "abandoned" by her "biological dad." Child L continues to feel this she describes her feelings of confusion not only regarding what she describes as being left by her dad but also confusion about her mother's partner who she describes and identifies with as "her dad." These feelings were asserted clearly, and he was misunderstood, she is understandably struggling to process not only what has happened to her, but by whom and the impact and separation of family members.

5.6 Whilst there was clear reflection about what life must have been like for Child L in the learning event this narrative did not appear to inform any intervention or enable her feelings to be heard, the prevailing narrative was that of her mother and mother's partner presenting Child L as the cause of many of the family's problems. This did not appear to be challenged by the professionals involved and subsequent responses to physical and sexual harm did not give her the understanding and response she needed to feel safe and listened to.

5.7 Positively when Child L commenced secondary school she was identified as vulnerable due to the child protection process. She was provided with additional support through a 'Refocus card'[15], and attended some group interventions aimed at promoting her resilience. Information was provided that implied she accessed her school counsellor, discussion within the learning event showed this was not the case. This may have led to some misunderstanding from other professionals about the level of support she was believed to be receiving particularly in the light of her self-harm episodes. Her take up of the behavioural support via the Refocus card escalated from 2 occasions in Year 7, to 136 occasions in Year 8 and 99 occasions in Year 9. This is a precipitous leap with no clear understanding of what may have been going on for Child L. Her attendance and behaviour deteriorated despite the acknowledgement of difficulties at home and in the community. The timeline shows this was a period of escalating involvement of harm both in the community and at home, including sexual exploitation, incidents of sexual harm and self-harm. Her school attendance (aged 13,) was at 24% and the school reported on the "rare occasions" she attended she refused to go to lessons, was "defiant and abusive" and was consequently at serious risk of permanent exclusion. Schools are a key protective factor for children at risk of intra and extra-familial harm. When speaking about school Child L became emotional and initially shared specific teachers who listened and helped her, then she wanted me to know it was "everyone" including the head teacher. It was noteworthy when we met, she was due to go attend a new school later that day and was anxious about this. The school was

[15] This was a card that students could use to receive additional support from the school inclusion team , it provided a room that students could access at any point during the school day if a student needed some time out and could be used as a preventative process to help manage emotions and behaviour. The card was to be used before any incident occurred

clearly a safe place and somewhere she had developed trusted relationships. It is critical that ways are found to ensure these relationships are maintained, trust is something Child L kept returning to in discussion with the lead reviewer.

5.8 Drug use increased for both mother and her partner and was accompanied by increased violence including drug dealers visiting the home, these incidents appeared to be managed as adult issues despite concerns being raised for the children's wellbeing. In April 2020 Child L's social care records show she was scared and upset following an incident where mother's partner banged her mother's head against the car door, the actions around this event and the allegation of physical harm will be explored below but illustrate the level of fear and violence within the family home that was known. Attempts to formalise mothers partner moving out of the home to address his substance use and engage with work around domestic abuse, the use of a Domestic Violence Protection Order (DVPO)[16] was short-lived, ineffective and had no consequences and mother's partner return to the family home was not supported by any risk assessment or work by mothers' partner. There were no improvements to life at home with continued domestic abuse and escalating drug use, the impact on the children would have been significant with ever present fear and anxiety. [17]

5.9 Child L shared physical abuse by her mothers' partner in September 2020 to school including her feelings about being scared of him. The multi-agency response following this initial disclosure of harm shows a poor understanding of why a young person might withdraw an allegation or not want to proceed with a formal process, meaning her voice was not heard or understood by the professionals tasked with keeping her safe.[18] The impact of this can be clearly seen in her distress following the disclosure of rape in January 2022 where she was bruised and intoxicated and was reported to say when she refused a medical that *"we won't do anything anyway".* Child L shared with the lead reviewer that when she asked for help no one believed her or understood her, she used the phrase "crying wolf" an adult expression where she explained this is what the professional said she was doing i.e., making things up for attention and she was simply not believed.

5.10 We can see from the timeline that within a few weeks of this was her first Missing from home episode, and within four weeks she had taken an overdose of Buscopan tablets[19] These were prescribed to mother, and positively work was undertaken to look at safety planning around the safe storage of medication. However, it must be noted that both parents were drug users and

[16] Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) aim to provide victims with immediate protection following an incident of domestic violence. https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-

[17] CAADA Final policy report In plain sight - effective help for children exposed to domestic abuse.pdf (safelives.org.uk)

[18] No one noticed, no one heard: a study of disclosures of childhood abuse (nspcc.org.uk)

[19] Buscopan is a medication used to relive stomach cramps linked to irritable bowel syndrome and period pain.

were associated with drug dealers increasing risks for the children in the household. Child L was admitted overnight to hospital and seen by Child and Adolescent Mental Health Services (CAMHS). Child L had three further self-harm episodes indicating the level of underlying distress she was experiencing from events within and outside of her home. Apart from CAMHS's acknowledgement of her vulnerabilities, and single agency pre-discharge planning, there does not appear to be a coherent multi-agency understanding of the adversity she has experienced and its impact on her mental health. This required a trauma informed understanding and approach. (See also learning point 12) Further support and intervention were also limited because mother did not bring her for follow-up appointments, this was a missed opportunity.

Learning Points 1, 2 and 4 reflect Partnership work established to address the JTAI (Action Plan July 2022- August 2023)

Learning Point 1 It is important that practitioners fully attend to the lived experience of children they are working with, this means they develop a good appreciation of what children see, hear, think, and experience on a daily basis within the context of their family, environment and people or events that might be impacting on the child's life.

Learning Point 2 Practitioners need access to regular reflective supervision to help them think critically and process the emotional impact of their work.

Learning Point 3 Adverse Childhood Experiences (ACEs) are significant predisposing vulnerability factors that contribute to the trauma experienced during childhood that can influence vulnerability around harm, abuse, and exploitation. Understanding what these are, their cumulative effect, and the impact for children and young people we come into contact with can support opportunities for prevention, protection, and effective intervention.

Learning Point 4 Education is a key protective factor for children who are at risk of both intra and extra-familial harm. Appreciation of the importance of relational practice , trusted adults and advocacy is significant where there is a risk of children being excluded and /or being moved and displaying behaviours that may reflect their distress.

Learning point 5 Repeated self-harm and overdose attempts are indicators of distress and or harm and processes around review and follow up in the acute trust and CAHMS (was not brought)should be strengthened to ensure children's needs are fully considered as part of a multi-agency plan to keep them safe.

5.2 Multi-agency responses to risk and harm - how are children responded to when they disclose abuse.

5.2.1 Ensuring the **child's voice** is at the centre of all safeguarding work is a fundamental principle of good practice and a **child-centred system** (Munro 2011) and involves not only 'listening' but observations of what children are experiencing or thinking through their behaviour rather than what they say. In this instance Child L shared what was happening to her at home and her

behaviours were indicative of her lived experience. Despite this Child L did not receive a child-focused response to the harm she shared and displayed. A key theme in all learning reviews focuses on the voice of the child, and analysis of these reviews [20] gives us four practice themes that to make a difference: attending to the child's lived experience, engagement with children, developing trusting relationships and practising curiosity about children's behaviours and disclosures.

5.2.2 Leaning from this review has already highlighted the importance of understanding the child's lived experience, the opportunity for Child L to develop a trusted relationship with her social worker will have been compromised by changes of social worker, five in the period in question. The rapid review also considered the impact of this on drift and delay and considered strategies, and tools that could have been utilised to support this such as the use of chronologies. The school share a positive relationship, and this can be evidenced by her ability to share her worries and harms she was experiencing. Maintaining this relationship was critical for this vulnerable young person and keeping her voice heard.

5.2.3 Of particular concern is the response to the disclosures of physical harm which led to Child L's voice not being heard and acted upon. The subsequent agencies' responses showed limited understanding of disclosures from the child's perspective, the context of her lived experience and an overreliance on possible prosecution processes. It is important that when a child makes a disclosure of abuse or neglect their allegation is taken seriously, and there is action to keep them safe. Child L in the period of the review has made three allegations of physical abuse in respect of mother's partner in the home, three allegations of rape and one of sexual assault outside of the home.

"Professionals need to be curious about children's behaviour and alert to behaviours that may indicate abuse or maltreatment. They should not rely unduly on verbal disclosure or children's denials or minimisation, where there is other cause for concern. Where children do talk about abuse it is important that professionals act on those disclosures".
(Learning for the Future December 2022 Dickens et al Department of Education)

5.2.4 The allegations of physical harm in September 2020 resulted appropriately in a Strategy Meeting discussion, the allegation was made at school, a place she felt safe, where she shared, that she was scared of her mother's partner, she stated he hit her and treated her differently to her (half) brothers, she described a miserable home experience and that mother's partner was in

[20] Learning for the future: final analysis of serious case reviews, 2017 to 2019 (publishing.service.gov.uk) Chapter 5 the voice of the child

the home. The DVPO had recently ended. Whilst this disclosure resulted in a joint visit with the police (and mother's partner was present) a decision is recorded there were no visible injuries, and that it was felt "*not to be in child L's best interest to get her to make a formal complaint and go down that route. The best course is for CSC to put in the safeguarding work with mum and the children "Mother* was spoken to and given responsibility for ensuring her partner stayed away. There was no information about the actions of mother's partner and the response did not demonstrate an understanding of intimate violent and abusive relationships. The failure to directly address the allegations of physical harm from Child L and to effectively challenge his presence in the family home did not ensure safety for her or give her any sense of being listened to.

5.2.5 Within five days there is information about a Missing from home incident involving Child L reported by the grandfather. It was reported that Child L returned before the police had been deployed and was therefore closed and the matter was left with the family to manage, consequently no safe and well check was undertaken or VPA made. This is a poor response as it does not consider the incidents could be related and appears to see the incident in isolation. Child L had just shared an allegation of physical harm and her worries about her home life. There was limited curiosity about this and is likely to have left her feeling isolated, and distressed and increased her vulnerability.

> *"The way adults respond when children begin to show or tell about possible abuse can determine whether they continue telling and therefore whether they can be kept safe"*
>
> *Best Practice when a child or young person might be showing or saying that they are at risk of harm. Marchant ,R*

5.2.6 In August 2021 Child L disclosed she was coerced into having oral sex with a 16-year-old male, appropriate statutory processes were followed. Child L declined to undertake an Achieving Best Evidence (ABE) [21] interview and subsequently withdrew her complaint, records show her mother did not support the complaint. Good practice was that this was followed up by the police to assure themselves this was the case. Learning was identified in the Rapid Review about a lack of follow-up with the alleged perpetrator by the police, whilst they spoke to the boys' parents, they did not speak to the young male not considering this a part of their processes, no referral was made to CSC to consider if any other safeguarding concerns were relevant which would have enabled a wider systemic view.

5.2.7 Child L disclosed two further instances of sexual abuse, in October 2021 she was seen at the hospital after consuming drugs and disclosed two adult males had sexually assaulted her, she was assessed at the Sexual Assault Referral Centre (SARC) but declined to give an ABE interview,

[21] An ABE interview is a video recorded interview with guidance on interviewing vulnerable witnesses.

records show her mother did not believe her, there was no independent advocacy for the Child L despite attempts to challenge mother's view by the police.

5.2.8 Child L then went on to make a further allegation of physical harm, discussions took place about the mother's partner moving out of the family home. Mother would not agree to this, and Child L went to stay with her grandparents. A study of disclosures of childhood abuse talks about the problem of 'linked disclosures'[22] which can lead to retraction and in this case compounded by the poor reaction of her mother and not feeling listened to. Nowhere is the decision making about mother's partner returning to the family home following the DVPO clear. Child L made disclosures, her behaviours demonstrated distress, but she was simply 'not heard' by her immediate family or the professionals involved with her for there to be a difference made.

5.2.9 It is notable that her self-harming behaviours were not seen by all professionals as a form of communication of the trauma she had experienced and consequently were not fully explored, resulting in a lack of understanding of the underlying reasons for her behaviours. The report of the Child Safeguarding Practice Review Panel annual review[23] reported the importance of practitioners building a trustful and respectful relationship with the child and critically reflecting on what the child is trying to communicate through their behaviour, and that practitioners should be aware that challenging or help-seeking behaviour may reflect harm and distress. (see also paragraph 5.4.8)

5.2.10 Escalating concerns about events at home led to a management decision to issue a Letter before Proceedings,[24] mother's partner was asked to live away from the home and parents to address their substance misuse problems. This was a positive response that demonstrated that the risks had then been appropriately recognised, however, for Child L her pathway to harm, and pathway to protection was becoming increasingly compromised. There were extended periods of missing and relationships at home were deteriorating further. Parental substance misuse remained problematic. The home situation did not improve as can be seen from the timeline and there was evidence mother's partner was back within the home contrary to the safety planning. It was some months later, in January 2022, that a senior management decision was made to issue legal proceedings requesting a Supervision Order.[25]

5.2.11 The level of trauma directly and indirectly experienced by Child L is evident in the records, in the days before the final incident of reported rape and concerns for her wellbeing were high. Her distress was captured by the police when she shared, she had, ***'no one to talk to about how***

[22] No one noticed, no one heard: a study of disclosures of childhood abuse (nspcc.org.uk)

[23] Child Safeguarding Practice Panel 2020 annual Report

[24] This is the pre-proceedings stage before an application for care proceedings in court. It is a letter sent to parents setting out the concerns the Local Authority has , the changes that need to be made to prevent the matter going to court and the timeframe for this.

[25] A Supervision Order is a court order that allows the locla authority to monitor and support a child who is at risk of significant harm under Section 31 of the Children's Act 1989.

she feels because she does not trust them, (she went on to describe how) she tattoos herself and does drugs and alcohol as a way of releasing how she feels.'

Learning point 6 Disclosures of harm involve interactions with children that means they are listened to with a clear focus on keeping them safe from abuse. Responses to children should not rely on whether they want to make a formal complaint, there is a lack of evidence or corroborating witnesses or the threshold for criminal proceedings is not met. This could be interpreted as disbelieving the child's disclosure.

Learning point 7 Where disclosures of harm are made consideration should be given to the need for a child protection medical in line with safeguarding procedures and advocacy for the young person where the disclosure may not be supported by family.

Learning Point 8 Understanding underlying trauma and its impact on behaviour and mental health is essential when working with vulnerable children and young people. Skilled trauma informed approaches can strengthen trust, develop relationships, and support interventions build resilience and recovery .

5.3 Multi-agency responses to risk and harm - sharing information and responses to domestic abuse.

5.3.1 It is important that all agencies **share information** they have regarding incidents and/or information that impacts a child's well-being and safety in a timely way. Whilst agencies may have responded to a situation for example following a **domestic abuse** incident unless it is shared it forms an incomplete picture of the child and family situation. Research also tells us that such an 'incident-based response' [26]can lead to a failure to see the fear and impact on victims particularly where domestic abuse features. Domestic abuse and violence were significant factors in the life of Child L, it is a factor in over 40% of cases notified to the Panel[27] as a key factor of child harm which highlighted a significant lack of understanding of the impact of domestic abuse across multi-agency partnerships.[28]

[26] Triennial Analysis of SCRs 2011-2014 - Pathways to harm and protection (publishing.service.gov.uk) page 80
[27] The process by which local authorities notify incidents to the child safeguarding practice review panel Report a serious child safeguarding incident - GOV.UK (www.gov.uk)
[28] Multi-agency safeguarding and domestic abuse (publishing.service.gov.uk)

5.3.2 There were some instances of domestic abuse, violence/harassment (drug debts) and several Missing from Home (MFH) episodes attended by the police but not shared at the time with the wider multi-agency group which is a significant omission given Child L was subject to a Protection Plan and the prevalence of domestic abuse and violence in the history. It also means that Safeguarding procedures were not always followed in line with Cheshire East Procedures about convening Strategies [29] , MFH and Working Together 2018. This resulted in the level of significant harm that Child L was experiencing did not inform ongoing multi-agency risk assessment, planning and review. It was therefore not able to challenge the effectiveness of the protection plan, or accurately record the lived lives of all these children. Significant work has been completed and overseen by the JTAI Improvement Plan ensuring Strategy Meetings are now routinely being held on all cases where the threshold is met and there is clear information sharing across the multi-agency group about incidents that require a multi-agency response to possible harm. (see also learning points 7 and 9)

5.3.3 The number of missing episodes could have identified developing risks around extra-familial harm; significant improvements have been made in this process and of relevance here is the appropriate trigger for a strategy discussion on all children missing for 24 hours ensuring a more coordinated approach to risks outside the home (JTAI Improvement Plan) [30] and escalation processes that includes independent oversight. (Pan Cheshire Missing from Home Protocol 2020 - 22) The JTAI Plan evidence this is an improving picture but needs to be fully embedded. The police also reflected, at the time, this was the period when the Missing from Home Team was newly created and developing systems and practice as a direct result of the JTAI Plan. Systems and practice are now fully operational, and all trigger points responded and coordinated with a multi-agency lens.

5.3.4 Sharing information is critical to keeping children safe and underpins effective multi-agency practice, for Child L this meant there was valuable information that was *knowable* but *not known* to all the agencies involved who form part of the multi-agency team. It is vital that events are viewed, analysed and risk assessed through a multi-agency and child-focused lens. For example, in July 2020 a significant domestic violence incident was attended by the police, and parental drug use was seen to have exacerbated the incident. This was witnessed by the children who were distressed, and it positively led to a DVPO and referral to MARAC being made, however, there was a missed opportunity not to hold a multi-agency Strategy Meeting to consider increased risks to the children and ensure all agencies were aware. In the event, a full MARAC was not held with deference being made to the current safeguarding process to ensure the safety of the victims. This limits the management of the risks from both an adult and child-centred perspective.

[29] Child Protection Enquiries - Section 47 Children Act 1989 (proceduresonline.com)
[30] CESCP Joint Targeted Area Inspection (JTAI) child criminal exploitation July 2022 , multi-agency Action Plan

Learning Point 9 & 11 reflects Partnership work established to address the findings from the JTAI (Action Plan July 2022 - August 2023).

Leaning Point 9 To ensure children are fully protected it is important that all services routinely share information about risks and harm to children, this includes incidents of domestic abuse and violence. Where there are existing individual child protection processes in place and the threshold for significant harm is met Multi agency Strategy discussion/meeting must be held, this includes open cases, to evaluate and consider information about a child or event impacting on a child through a multi-agency lens.

Learning Point 10 All practitioners and managers need to be fully aware of the varying impacts of domestic abuse on children this includes being domestic abuse aware and trauma informed and seeing and hearing the child in the context of their lived experience.

Learning point 11 Missing is a significant vulnerability and risk factor for extra- familial harm Practitioners and managers need to have greater understanding of this and be confident to use the new Pan Cheshire Missing from Home Policy (2020-2022)to identify patterns, harms, and possible exploitation for children they work with.

5.4 How does the partnership respond to vulnerability and manage risk regarding child sexual exploitation (CSE)[31]

5.4.1 Whilst the practitioner group were able to share greater awareness around identifying and responding to CSE, linking in with missing episodes since the incident with Child L and improvements since the JTAI, there were still some uncertainties about pathways and process. This focussed in discussions on the use of the Exploitation Tool, and how risks outside the home are managed from the front door including pathways for cases they were working with. At the time, the use of the Child Exploitation Screening tool[32] could have been used to identify and review the contextual risks Child L was being exposed to and consider preventive or disruptive actions as a multi-agency response CSE and grooming. (see also learning point 11)

5.4.2 Safeguarding children at risk of exploitation is complex and requires a wider appreciation of harm to the more traditional multi-agency child protection processes, notwithstanding our duty to

[31] Child sexual exploitation (CSE) is a type of extra familial harm . When a child or young person is exploited, they are given things, like gifts, drugs, money, status, and affection, in exchange for performing sexual activities. Children and young people are often tricked into believing they are in a loving and consensual relationship. This is called grooming. They may trust their abuser and not understand that they're being abused. Child sexual abuse and exploitation | The Children's Society (childrenssociety.org.uk)

[32] Contextual Safeguarding (cescp.org.uk)

safeguard children in interagency working makes it must be clear that "*it's not about structures it's about making it work out there for children*" Laming 2009[33]. In Contextual Safeguarding and Child Protection, Carlene Firmin [34] develops a theoretical approach that provides a framework to develop systems to consider **extra familial harm** experienced by adolescents out of the family home such as child sexual exploitation (CSE)and child criminal exploitation (CCE), peer abuse and gangs. It does this by placing the focus of professional assessment and intervention towards the places and spaces (including virtual) friendship groups and communities that adolescents occupy. Child L was subject to multi-agency child protection processes and whilst the risk of exploitation was discussed within this arena it did not incorporate any contextual safeguarding expertise and there was a feeling that this needed to be given more attention providing a more holistic assessment. Sadly, what seemed to have occurred in these meetings was that the focus was on child L's behaviour, presented by her mother and mother partner, that she was to blame and was **'***putting herself at risk'* by making poor choices and not being truthful. The use of such inappropriate language can be a significant barrier to protecting young people. [35]

5.4.3 Responses to Child L showed limited understanding of the links with her developmental stage, vulnerability to CSE and extra-familial harm. Positively there were two attempts to show curiosity by the police and CAMHS by considering undertaking a CSE screening tool. However, only the police undertook one in October 2021 following the disclosure of sexual assault by two adult males. Whilst this was good practice, and she was identified for a brief period at the end of 2021 to January 2022 as being at risk of sexual exploitation this does not appear to have formed a clear plan around sexual exploitation at the Multi-agency Contextual Safeguarding Meeting in December. The outcome of this meeting was she was no longer flagged at risk of CSE which given the information that was known it is difficult to understand this decision. Instead, the risk was viewed as an isolated event, to do more with her peers and there was no consideration of the ***'grooming process'***[36] as part of a systemic process of sexual exploitation. This was a missed opportunity to intervene robustly by the multi-agency parentship and work with the child protection plan and showed limited understanding of contextual safeguarding and sexual exploitation. Current practice is improved with the establishment of Child Exploitation Teams led by the police across the authority.

5.4.4 From as early as May 2021 there was evidence of Child L being groomed sexually with indecent images found on her phone, and whilst police spoke to Child L about online safety it is not clear that professionals were subsequently curious about this. There were two further episodes

[33] The Lord Laming 2009 The Protection of Children A progress Report in England Chapter 4 Interagency working
[34] Firmin, C, 2020 Contextual Safeguarding and Child Protection :Rewriting the Rules Routledge Group
[35]. Eaton J & Holmes D. (2017). *Working Effectively to Address Child Sexual Exploitation: Evidence Scope (2017)*
[36] Grooming is a process that "involves the offender building a relationship with a child, and sometimes with their wider family, gaining their trust and a position of power over the child, in preparation for abuse." Grooming: recognising the signs | NSPCC Learning

of self-harm over the next few months including reports that she was sharing photos of how-to self-harm online. In this same period, she disclosed she was coerced into having oral sex with a young male, and soon after she disclosed sexual assault by two elder males. The police worked with the social worker to complete a piece of work with Child L about online activity, whilst this is positive practice it does not show curiosity about possible exploitation given her predisposing vulnerabilities and the developing evidence of extra-familial harm and exploitation.

Sex offenders in CSE are not a homogenous group. They vary in the time they take to groom children, and, in their tactics, manipulation, charm, threat, intensity and general style, which tends to reflect the personality and goals of the sex offender, not the vulnerabilities or life of the child (European Online Grooming Project, 2012).

5.4.5 In this same period Child L was noted as being involved in antisocial behaviour, fire setting, drug and alcohol use and was reported missing for extended periods, including being found in a neighbouring city. A disclosure of rape was made with Child L distressed, bruised and under the influence reported to say when she refused a medical not believing anything would come of this. (see page 11, 5.9)

5.4.6 In March 2022 two disclosures of rape by an adult male she had been messaging on Snapchat led to the subsequent discovery that the alleged perpetrator was a registered sex offender, and this was the incident that led to the significant incident notification.[37]

5.4.7 This is a distressing journey of sexual exploitation and abuse and would have been an extremely abusive and traumatic experience for Child L. There were opportunities for professionals to identify and respond to indicators of exploitation and sexual abuse, but the multi-agency response failed to adequately understand the most common signs of CSE and intervene [38] Whilst individual events were responded to, they did not inform a coherent picture, there were attempts such as the police response to the fire setting where her vulnerabilities were recognised and the individual responses to herself-harm by CAMHS. However, there was no coordinated assessment, response, or recognition of trauma and curiosity about what this could be related to. There is evidence of professionals identifying issues for example the school nurse spent time with Child L in February 2022 where she disclosed that she was having sex, and it was not always consensual however the outcome of this interaction is not known other than it was passed to mother and the social worker. This was a missed opportunity to offer support and intervention and explore aspects of sexual abuse and exploitation directly with Child L to try and keep her safe.

[37] Notifiable serious incidents are those that involve death or serious harm to a child where abuse or neglect is known or suspected, and any death of a looked after child. Serious incident notifications, Methodology – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

[38] Child sexual abuse and exploitation | The Children's Society (childrenssociety.org.uk)

5.4.8 Child L spoke to the reviewer about a significant practitioner who had helped her. In July 2021 a referral for intensive family support was made by Children's Social Care, Child L described her worker who had helped her from this service and shared things that had made a difference for her such as enabling her to express, "It's ok not to be ok" and providing her with space to talk about her feelings, she talked positively about this worker who took her out and spent time one to one with her. This was someone who she felt really listened, did not judge, and helped her with trying to unpick some of the things that were going on for her. This was a 'reachable moment that occurred when events were escalating at home (see timeline) she was with her grandparents following the disclosure of physical assault by her mother's partner, was starting to go missing, school attendance was poor and at risk of exclusion, she was self-harming, disclosed sexual assault by two men and was involved in antisocial behaviour in the community. Commissioning for this service transitioned in this period and social care reported this coincided with more challenges of engagement for Child L and her family. From Child L's perspective, the impact was she had lost someone she identified as a "trusted person"[39].Whilst the evidence is developing around the effectiveness of trusted relationships in supporting children at risk of harm from exploitation there is a clear logical link [40] as can be seen by the direct evidence from Child L that this was a further loss and impacted her ability to trust professionals. When services are commissioned/decommissioned it is important that a relational approach is considered.

Learning Points 12 and 14 reflect Partnership work established to address the JTAI (Action Plan July 2022- August 2023).

Learning point 12 Practitioners and managers working with vulnerable adolescents need to be supported to understand the key signs of child sexual exploitation and abuse. This must also include a good understanding of adolescent development. (see also learning points 6 & 8)

Learning point 13 The use of language is important and victim blaming language that implies the young person is responsible for the abuse or putting themselves at risk must be avoided as this is a barrier to protecting young people. This must be challenged across the partnership.

Learning Point 14 Practitioners need to be supported to use the CECSP Multi Agency Assessment Toolkit, Screening tool and Guidance with regard to child exploitation.

Learning point 15 There are a number of critical or "*reachable"* moments or events in young people's lives, particularly **early on** in the problem where they may be more receptive to change. Services and practitioners need to be vigilant and curious about these opportunities, including early indicators of risk and harm. These include disclosures of harm, exclusion from school, hospital admissions arrest and critical incidents.

[39] Safeguarding children at risk from criminal exploitation review.pdf (publishing.service.gov.uk)
[40] Building trusted relationships for vulnerable children and young people with public services | Early Intervention Foundation (eif.org.uk)

5.5 Understanding how adult issues impacted parenting.

5.5.1 Adult issues of domestic abuse, parental substance misuse and criminal behaviours featured extensively in the family of Child L. Research tells us that the presence of one of these issues does not necessarily mean parenting will be significantly compromised or children will necessarily suffer significant harm. It is the **co-existence**[41] and in the case here, substance misuse and co-dependency, that presents the greatest risk to children "*For some children, adult-oriented issues intrude into their daily lives in such a way as to radically impact on their wellbeing."* (Murphy & Rogers 2001 Working with Adult Orientated issues)

5.5.2 Child L's family was experiencing multiple problems related to these issues and was well known to adult and children services. Effective intervention requires collaboration and understanding from a whole family perspective to improve parenting and address adult issues. The problems within the family were chronic and complex with features – drug use - that led to exacerbated family and community violence. Many of the resulting preoccupying adult behaviours of denial, avoidance, minimisation, mood swings, violence, intermittent engagement and blame seriously compromise their ability to be ready to engage with the necessary interventions to firstly stabilise, address their adult issues and then enable them to parent and meet their child's needs.

5.5.3 There were services in place to support the family but the patterns of engagement, and delay in seeing and analysing this meant there was no critical exploration of what this meant for Child L and her siblings being impacted by these issues. The multi-agency child protection process would be the place for collaboration and critical reflection with the identified specialised adult services to support and review the changes needed. All professionals felt the child protection process had led to drift and delay, there but there is no clear challenge or escalation by the professionals tasked with keeping her safe involved and no clarity about what was getting in the way of this being escalated.

Learning point 16 Assessing the impact of adult issues on family life and the children requires a collaborative whole family approach to fully appreciate the extent of the difficulties the adults present /experience. The increased risks of co-existing adult issues needs to be fully considered when assessing the impact and risk on children and parenting within families where these issues feature.

Learning Point 17 The importance of critical thinking and professional challenge in challenging attitudes and assumptions is a key component of multi-agency working and is supported by reflective supervision and skilled practice leadership.

6. Summary and Recommendations for the Partnership

6.1 This practice review has identified a number of key themes for the partnership to consider and reflect upon regarding improvements for multi-agency systems and practice and understanding of vulnerability and harm. Practitioners worked hard to engage with the family and Child L over an extensive period with a range of services and interventions attempted. There were examples of good and effective practice identified across the partnership and highlighted in the report.

6.2 It is noteworthy that Child L was not hidden, she was visible and subject to child protection processes for over two years and assessments, plans, services, and interventions were put in place, practitioners and services could talk *about* her and her voice and her behaviour was *captured*. However, she was simply *not heard* and understood and despite the multi-agency system around her she was not and did not feel safe in, or outside her home, heightened by her disclosures that she could not trust anyone to share the harm she had experienced. She experienced significant harm both inside and outside of her home environment and attempts to build safety in either context were compromised by a range of factors and practice issues highlighted in this review thematically through the child's lived experiences, the multi-agency responses to risk and harm, how CSE is understood and managed and the co-existence of adult issues compromising the care and protection that the family was able to provide.

6.3 Understanding the events and circumstances around Child L's pathway to harm has identified a number of key aspects that could support understanding and learning centred around key practice and system learning summarised below. Whilst some of these reflect learning and improvements made as part of the JTAI Improvement Plan, it remains important that learning from this review directly informs and strengthens practice and system changes.

Recommendations for the Safeguarding Children's Partnership

Having considered the learning from this review that has not been addressed by the JTAI Improvement Plan the following recommendations are made:

1. The Safeguarding Children's Partnership to consider how it can strengthen practitioner skills that enable the child's voice and experiences to be listened to and responded to whether there is a verbal or non-verbal disclosure. This needs to include child observations and understanding of behaviours that may reflect harm and distress.
2. The Safeguarding Children's Partnership to seek assurance that disclosures of harm and abuse fully consider the need for a child protection medical in multi-agency meetings/discussions to ensure they are compliant with Working Together.

3. The Safeguarding Children's Partnership to work closely with the Safer Cheshire East Partnership to ensure work currently being undertaken (to review the National Panel's briefing paper on Multi-agency safeguarding and domestic abuse (2022)[42] is fully sighted on the learning from this review and national learning from LCSPR's with regard to prevalence and risk relating to domestic abuse and developing a whole system think family response that considers other adult risk factors.
4. The learning from this review is shared across the partnership and supports the developed understanding of child sexual exploitation and extra-familial harm and specifically what this means for practice. Assurance of progress should support established multi-agency audit processes developed as part of the JTAI improvements including direct feedback.
5. The Safeguarding Children's Partnerships work undertaken as a result of the JTAI with regard to the role of education in providing a key protective factor should include learning about the importance of relational practice, trusted adults, and advocacy where children are at risk of being excluded and/or moved and displaying behaviours that many reflect their distress.
6. The Safeguarding Children's Partnership to provide clear leadership and challenge about victim-blaming language.
7. The Safeguarding Children's Partnership to seek assurance that when services are commissioned/decommissioned that a relational approach is taken with regard to children and families to be mindful of the importance of continuity of relationships from the child's perspective.

[42] Multi-agency safeguarding and domestic abuse (publishing.service.gov.uk)