

1. Background

A large sibling family moved into Shropshire in 2019 having previously been on a Child in Need and Child Protection Plans. There were historic concerns of neglect and abuse, including sexual abuse and sexualised behaviour of an older sibling, clear indicators of mum and step-father's inability to protect the children, to parent them safely and to meet their basic needs. In December 2023 the father to the youngest child and step-father to the other siblings was arrested following intelligence that he had shared

2. Background continued...

abusive images of his step-daughter with a known paedophile. There were clear concerns regarding harmful sexual behaviour between the siblings and with peers and evidence of significant blurred boundaries in respect of sexual behaviours, use of sex toys, access to pornographic and abusive material. The presence of CCTV and proliferation of lockable doors raise clear concerns regarding abuse and neglect within the home.

3. Application of thresholds

Where agencies have concerns over the determination of thresholds and outcomes they should discuss this with the decision-maker and if they still have concerns then they should use the SSCP Escalation Policy.

Where Early Help Services have been tasked with undertaking inappropriate work then this should be escalated to the Service Manager for discussion with Children's Social Care.

8. Lack of understanding of neglect

When one child is being treated differently, e.g. does not have an allocated bed, consideration should be given to if the child is being scapegoated and neglected. Practitioners should use the [Neglect Screening Tool](#). When the [Neglect Screening Tool](#) has been completed and it is deemed satisfactory a follow-up visit should always take place to assess if the situation and home circumstances have been maintained or have declined.



4. Professional Curiosity

Professional curiosity should be exercised by all practitioners. What parents say should be explored and considered alongside what multi-agency practitioners are seeing, what children are saying, and any previous concerns documented in case records. Practitioners need to be mindful that parents may be using disguised compliance or diversionary tactics to take attention away from concerns for the children. [Learning Event Professional Curiosity SSCP](#)

7. Lack of understanding of sexualised behaviours

All agencies to ensure that practitioner's awareness of the warning signs and indicators of inter-familial sexual abuse is improved. All practitioners should be professionally curious by considering and exploring other reasons for children displaying sexualised behaviours and not to assume it is as a result of a diagnosed neuro-developmental order. [Understanding sexualised behaviour in children \(NSPCC\)](#)

6. Lived experience of the child/ren

The daily lived experience of the child/ren needs to be explored and understood by all practitioners. If practitioners are observing dirty home conditions, outside locks on internal doors, CCTV installed in bedrooms and are aware children are being home educated (some examples as evident in this case, not an exhaustive list) consider how that feels for the child/ren, speak to them about it and gain their views of what a day in their life looks like for them.

5. Information sharing

There were a number of incidences of information not being appropriately shared in this case. Bee U were made aware by the mother that there were locks on internal doors in the house but this was not shared with any other agency or considered a safeguarding concern. Bee U should triangulate and share information with agencies that they know to be involved with a child and family.

9. Missing Education

Consideration needs to be given to reporting concerns about students with Special Educational Needs and Disabilities (SEND) who are not attending their college or Post 16 provision. Where parents do not engage and do not advocate for their child then this should raise concerns.

Schools should consider how they can have eyes on children who they have concerns about and who are absent from school.

10. Online safety training

All practitioners should ensure they have received online safety training, are aware of age restrictions for social media sites and are alert to the fact that where parents are willingly allowing their children to access such sites whilst underage that is an indicator of neglect.

11. Feedback to referrers

Feedback should be given to referrers on the outcome of a referral and be clear about why a referral does not meet a threshold. Ideally a discussion should take place with the referrer to ensure understanding of the outcome. Where no feedback has been received then the referrer should request this of Children's Social Care and follow the Shropshire Safeguarding Community Partnership (SSCP) Escalation Policy if feedback is still not received. [Escalation policy: Resolution of professional disagreements](#)



12. Information sharing

Practitioners in Children's and Adult's Social Care to ensure that when sharing information with each other that they share all relevant information about the child/adult/family including the history and risks as the IT systems for services are not linked.

When a family move into the area and they are on a Child in Need (CIN) plan, consideration should be given to liaising and sharing key information with School Nursing Services.

14. Take away messages

- Consider barriers for families accessing services
- Take a whole family approach and consider the lived experience of the child/ren
- Ensure you understand sexualised behaviours, neglect and online safety. Use the practitioner resources available to you
- Share information with agencies working with the family

13. Support for Young Carers

Practitioners who are made aware that a child is a young carer should explore with the child what that means for them and how it impacts them. Practitioners should signpost them or provide them with appropriate support.