Child Safeguarding Practice Review

The long-term sexual abuse of children in care

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1 Introduction

1.1 The Wiltshire Safeguarding Vulnerable People Partnership (SVPP) agreed to undertake a Child Safeguarding Practice Review (CSPR) to consider the risk of sexual abuse for children living in foster care. Consideration was given to a case where allegations of long-term sexual abuse from their foster carer were made by siblings in 2021. Although a rapid review had taken place which had identified some learning, the seriousness of the allegations meant that the SVPP wanted to consider additional learning about the way that agencies work together to safeguard children in foster care and commissioned this review.

1.2 Learning has been identified in the following areas:

- The vulnerability of children in care to sexual abuse
- That there may be no obvious child or adult behaviours that indicate sexual abuse
- The need to always consider the potential for sexual abuse
- The importance of consistent and meaningful relationships with professionals, so that children living outside of their birth families have regular contact with people they have confidence in and can trust
- The need for professionals to take opportunities for introducing the subject of sexual abuse in conversations with children
- The need for full engagement of both carers, even if one is seen as the 'primary carer'
- The need for training for foster carers about intra familial sexual abuse

Although it is recognised that much of what was found in this case is not new learning, it was agreed that this was a good opportunity to highlight what was found in order to provide points for discussion amongst professionals in partner agencies.

2 Process

2.1 An independent lead reviewer was commissioned[1] to undertake the review alongside a group of local professionals. This report[2] summarises the learning from the review, which built on the detailed information provided as part of the Rapid Review process undertaken shortly after the allegations were made. Good practice in how practitioners worked with the siblings and the carers is evident throughout the case, however relevant learning has still been identified.

2.2 Despite the impact of COVID 19, professionals involved with the children at the time were meaningfully involved in discussions about the case and practice more generally, as part of the review. Those involved in processes for assessing and scrutinising of placements were also part of a focused discussion.

2.3 The key lines of enquiry established at the start of the review were to; consider the confidence of professionals in this area of safeguarding; ensure a more curious approach by professionals regarding sexual abuse; and to establish how professionals can speak to children about sexual abuse in long term placements, including children with special needs. It was agreed that the review should include a detailed understanding of the management of the sibling's daily care plan, safer care assessments and plans, the assessment and oversight of the secondary carer and the transitional care plan for the eldest child.

3 Case Information

3.1 The children considered are a sibling group of three who were placed with the carers in 2012. It was their first placement after coming into the care of the local authority. There had been significant concerns about abuse and neglect from their own family, including suspected intra-familial sexual abuse. It was later agreed that they should remain with the carers as a long-term fostering placement.

3.2 The eldest was 18 years old at the time that the abuse was disclosed but was a child living in the household during the period the sexual abuse has taken place. She has global development delay, learning difficulties and ADHD. She attended a special school and is now at a residential college. The middle child was 16 years old and attends a mainstream school. She is making good educational progress and aspires to go to university. The youngest child was 15 years old and has an EHCP for behavioural and emotional health needs and learning difficulties and attends a special school.

3.3 The foster carers considered are a male and female couple who have been fostering for around 15 years. They were assessed and supported by an independent fostering agency (IFA). They live in another local authority area. The placement was long-term, stable, and seen as child-centred and nurturing.

3.4 Disclosures of sexual abuse perpetrated by the male carer were made by the middle child to her female foster carer. She stated that the abuse had been happening repeatedly for around nine years. When interviewed[3] her younger sibling also made allegations of sexual abuse from the male carer. Having admitted numerous counts of rape and sexual assault, the male foster carer is currently serving a lengthy custodial sentence.

4 Family engagement

4.1 The lead reviewer met with the female foster carer and the two younger children during the review, along with a representative of the SVPP. Learning was established from this engagement and is included in this report.

4.2 The children's mother will be informed of the learning from the review. She was not interviewed as she does not have contact with her children.

[1] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the WSP.
[2] This report has been written for publication. It only contains the specific case information that is required to identify the learning.
[3] Timely Achieving Best Evidence (ABE) interviews were undertaken with the children. Child protection medicals were not undertaken as the foster carer admitted to the abuse, but the children's health needs were appropriately considered.

5 Learning identified

5.1 It is apparent that, even with the benefit of hindsight, there were few if any indicators that the children in the household were being sexually abused prior to the disclosure. Research shows that children who are being sexually abused often show symptoms that may lead those caring for them or working with them to wonder if something is wrong. Classic symptoms in teenage girls are eating disorders, self-harm, anxiety and depression, drug and alcohol misuse, and difficulties in coping with stress.

5.2 The middle child was doing well at school and had friends. There was no indication that she was particularly unhappy or distressed. The youngest child has learning difficulties which presented her with challenges, but she was receiving appropriate educational support. She was exhibiting some self-harming behaviours, such as scratching herself with a ruler at school, which professionals' thought was linked to issues with her peers and to her diagnosed longer-term attachment difficulties. There was no indication from the child or the carers that there were any issues within the home. She was thought to be happy with the foster carers and wanted to change her surname to theirs. This reassured professionals of the strength of the placement, however it can now be acknowledged as an indicator of the complexity of the emotional impact for children who are being abused by someone they care about.

5.3 The eldest child, who has complex special needs, has not disclosed sexual abuse, but was very unsettled in the two years preceding her sister's allegations. She was possessive of her female foster carer and the relationship with her siblings was difficult. Much of the support and professional engagement at the time was in respect of this child, due to concerns that she may not be able to remain living with the foster carers as an adult, which had originally been the plan. Both younger siblings voiced the difficulties they had in managing and living with their sister's difficult behaviour, which included shouting and throwing things. It is not known if this behaviour was due to sexual abuse, but any changes in behaviour need to be considered as a possible indicator of abuse, particularly when the child has communication difficulties and may not recognise abuse, as was the case here.

Learning point
A child who is being sexually abused may not show any obvious symptoms that suggest they are being abused.

5.4 When a child in care does show challenging behaviours or signs of distress, it is often ascribed to negative experiences when they were younger or to other experiences since coming into care, such as placement breakdowns. Professionals need to ensure that they are alert to the possibility of other causes, including current sexual abuse. While any child can potentially experience sexual abuse, some are likely to be more at risk, for example children who have experienced other forms of abuse[4] like those being considered by the review. Children in care are particularly vulnerable to sexual abuse due to their previous experiences[5]. York University and the NSPCC conducted research in 2014 and concluded that while the vast majority of foster carers do an excellent job in often difficult circumstances, most abuse or neglect of children in foster care is perpetrated by their carers rather than outside of the home. They found that there are between 450–550 confirmed[6] cases of different types of abuse or neglect in foster care across the UK each year[7] and that around 11 per cent of this abuse is sexual.

[4] Finkelhor, Ormrod, and Turner (2007) Poly-victimization: A neglected component in child victimisation

[5] The Prevalence of Child Sexual Abuse in Out-of-Home Care: A Comparison Between Abuse in Residential and in Foster Care. Saskia Euser et al (2010)

[6] These findings are likely to underestimate the true extent of the problem, as over half of the unsubstantiated allegations could not be proven one way or the other.

[7] The figures were taken from referrals to the LADO (Local Authority Designated Officer) in respect of carers, to ensure they did not include abuse of children in foster care outside of the home.

Learning Point
Any challenging behaviours need to be considered in light of the child's **current** life, as well as past events.

5.5 Research tells us that despite the scrutiny of professionals and oversight of the placement, children placed with carers outside of their birth family remain at risk of abuse and neglect and can be re-abused in these situations. In this case it was suspected that the children had been sexually abused while living with their birth family, and extensive work had been undertaken with the children earlier in the placement to support appropriate sexual behaviours and relationships. Both PCAMHS[8] and the NSPCC provided individual direct work appropriate to each child's learning needs in 2014-15. This provided a degree of reassurance in this case because this work had been undertaken and was seen as successful at the time. Both the rapid review and the CSPR discussed the potential need to revisit work such as this as the children get older, and for the work to be reviewed and adjusted in response to new situations such as at puberty and when the plan changes, as it was when the older child was moving to a residential college. Both of the children had some memories of the work undertaken, but when discussing this with the lead reviewer they stated that they did not particularly consider it when the abuse started and continued.

Learning Point
Professionals should not assume that when a child has had therapeutic interventions that this will be protective in the longer term.

5.6 Two of the children in the placement have learning difficulties and this too can increase their vulnerability. One of these children has disclosed sexual abuse from the male carer, and there is the possibility that the other may also have been abused although she has not disclosed. Those who were spoken to as part of the review were aware that children who have disabilities are at an increased risk of being abused compared with their non-disabled peers[9]. Studies[10] have shown that disabled children are three times more likely to be sexually abused and that just less than a third of disabled children suffer at least one form of abuse compared with 9% of the non-disabled child population.

5.7 One of the difficulties for professionals when a child has a disability is how to determine what behaviours are due to the disability and what may be an indicator that something else is going on. The Children's Commissioner Report 'Protecting Children from Harm' states that "children with a learning disability may exhibit behaviour which, although indicative of sexual abuse, may be attributed to the learning disability itself." In this case some concerning behaviours were noted but as they could be attributed to other issues that the children were experiencing at the time, sexual abuse was not considered. It was recognised that in the two years prior to the disclosures much of the professional focus was helping the carers to manage the increasingly difficult behaviours of the eldest child. Most of the direct and indirect contact between the fostering agency and the female foster carer involved discussions about this, which was understandable as a lot of support was required. The impact of this child's behaviour on the other children was also considered regularly, and it was noted that things were incredibly difficult for the whole family. The concerns led to a plan to provide a residential educational setting for the eldest child, which in turn exacerbated the child's distress as there was uncertainty about how to best meet her needs and some delay due to issues about funding of the placement. This was thought to account for any difficulties in the home at the time.

[8] Primary Child and Adolescent Mental Health Service
[9] Jones et al (2012) Prevalence and risk of violence against children with disabilities
[10] Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and Disabilities: A Population-Based Epidemiological Study. Child Abuse & Neglect

Learning Point
As children with disabilities are more vulnerable to sexual abuse, professionals need to ensure that this is considered when their behaviour is being assessed.

5.8 Not only were there no historic concerns in relation to sexual abuse from the male foster carer, there were no concerns whatsoever about the quality of care provided to the children or the motives of the carers at any stage during the placement. In the foster carers annual review in 2020 the IFA fostering panel stated that they would like to 'give huge thanks and praise to (the carers) for the ongoing love, care and dedication they continue to give to (the children). The "togetherness" they show as a family, despite challenges, is remarkable.' All of those involved at the time agreed during the review that the placement was thought to be excellent. All of those who observed the children with the male foster carer noted a close and appropriate relationship. There were no indicators that anything was wrong or that his relationship with the children was inappropriate in any way. This CSPR reflected that as a foster father he was visible, while he kept his abuse of the children invisible.

5.9 The middle child told the review that if professionals are not looking for sexual abuse they won't see it, while acknowledging that it was well hidden in her case. No one involved at the time considered the possibility of sexual abuse from a well liked and trusted foster carer; such a thing was 'unthinkable.' Due to the high regard for the carers and their commitment to the children in this case, and despite the eldest child's behaviours, there was no consideration of abuse within the placement. The child told the review that her male foster carer was very confident that he would not be detected and took any opportunity to abuse her. For example, he would sexually assault her in the kitchen while her female carer had turned away to the cooker. He also made her question her knowledge about sex and relationships, undermining the female carer's careful work in this area.

5.10 Even with the benefit of hindsight, there were few common 'grooming' techniques used by the male foster carer that could have been known to the female carer or any professionals working with the family. The purpose of grooming is to reduce the likelihood of detection or the child disclosing, and reducing the chance of the child being believed if they do disclose. As well as grooming children, perpetrators also groom and manipulate the adults around the child and the professionals involved. Perpetrators can be charming, or they may intimidate and frighten professionals so that they are distracted from their abusive behaviours. Grooming behaviours can be very subtle. They include favouritism within a family of a particular child and making the child depend on them.

5.11 The disclosure made by the middle child at the time included information on how her carer groomed her. He sometimes gave her cash and gifts of downloadable video games, seemingly chosen as the female carer would not have been aware of this. He also made threats, including about her having to leave the household and her much loved female carer if she disclosed what was happening. He successfully groomed both children and avoided detection for a considerable number of years. The children told the review that the abuse progressed from sexual touching to rape over the course of the offending. Neither sibling knew that the other was being abused as well, although they both were alert to the possibility so tried to monitor the male foster carer around the other child. This gives an insight into the ability of the abuser to keep the abuse from each sister, as well as from his wife.

5.12 The SVPP published a CSPR in May 2021 (Family N) that featured sexual abuse in the home. The learning from the review highlights that children are less likely to disclose sexual abuse than other forms of abuse and that it is often 'silent and hidden.' Many of the ways that a perpetrator can silence a child were evident across both reviews, and entirely unknown to professionals at the time. The Child N review quite rightly points out that any direct work with children needs to understand the 'silencing methods' and not be too direct. Unlike the foster carer being considered here, the perpetrator in Family N was known to be a sexual risk and was intimidating and threatening to professionals.

Learning Points
All professionals need knowledge and confidence about adult behaviours that might indicate a sexual risk to children.
All professionals need to be able to consider the 'unthinkable' about carers who they may know well and who they may work closely with and be alert to the possibility of sexual abuse.

5.13 There was reflection from the professionals involved in this case that the majority of their contact was with the female foster carer who was a 'stay at home' carer and undertook most of the day-to-day tasks in respect of the children. She met most of the fostering expectations such as report writing and liaison with professionals. She was particularly efficient and exceeded expectations of the role. This type of division of childcare and fostering tasks is not unusual in a placement were one of the carers stays at home and the other works. The roles are not always determined by gender, although it was a 'traditional' set-up in this case. There is often learning within case reviews that fathers or males in households are not considered equally by professionals. In this case, while the vast majority of contact was with the female foster carer, the expectations of the male carer during assessments and reviews were clear and largely complied with, including him attending supervision with the IFA social worker when required. Both carers were seen with the children. The male carer was well known to the fostering agency, would attend fostering agency events such as barbeques, and had attended some men's group sessions in the past.

5.14 The supervising social worker and others in the IFA felt they had a good relationship with both carers although the majority of their contact was with the female carer. The male carer's job involved him being 'on-call' and this was known to have an impact on his availability to meet with professionals. This was not unusual in the experience of the professionals spoken to about the case however, and there was no indication at the time that he was avoiding professionals or had any issue with their oversight and presence in his home. A number of different professionals saw him regularly with the children and described positive and appropriate contact and relationships. It was pragmatic that the majority of professional engagement was with the stay-at-home carer, but this means that the other carer will not be as well-known to professionals and subject to less scrutiny.

Learning Point
When professionals predominantly work with one carer, they need to ensure that equal professional scrutiny applies to the second carer.

5.15 One of the issues considered by the review is the length of time that the children were being abused without detection and without them telling. The middle child disclosed that the abuse had been happening for around nine years. It is important that professionals are aware that any child who is being sexually abused is unlikely to make an allegation, particularly when the perpetrator lives with them. NSPCC data suggests that seven years is the average time from start of sexual abuse to disclosure for those that do disclose[11]. Many children never disclose, only partly disclose, or disclose and then withdraw their allegations. The younger the child is when the sexual abuse starts, the longer it takes for them to disclose.[12]

5.16 It is a reflection of her faith in the adults she trusted, particularly her female foster carer, that the middle child made her allegations when she did. She spoke to the lead reviewer about what would have helped her to disclose sooner, and the main motivator would have been if she had known that her younger sibling was also being abused. She was not aware of this however and planned to tell prior to going to university so that her sister would be 'safe'. She stated that she wanted to control when her disclosure was made, and that she would have struggled had a disclosure been 'forced'

[11] 'No one noticed no one heard' 2013
[12] Debbie Allnock and Pam Miller (2013) No One Noticed, No One Heard (NSPCC)

from her, for example by direct questioning, until she was ready to tell. She was very clear that she wanted to control the narrative in this regard, and that she was able to 'put on an act' to ensure no one knew what was happening in order to have this control. She said that she feels sad that her sister was not able to decide when to disclose, as the younger child's disclosure closely followed her sister's.

5.17 The 2017 report published by the Children's Commissioner 'Making Noise: children's voices for positive change after sexual abuse' found that concern about being believed and the absence of support following a disclosure was one of the most common silencing mechanisms in these cases. The middle child told the review that the foster carer's threats had been escalating over time. She knew that she wanted to disclose, but she wanted to get evidence to ensure she was believed. She was able to record her foster carer making threats to her, which she shared with her female carer when she made the disclosures. It is important that professionals and foster carers are aware that sexual abuse and emotional abuse co-exist. In this case both children were subjected to on-going emotional harm from their male carer. The children spoke about him having a 'look' that he gave them when he was intending to abuse them. This was often in front of his wife or other family members. This led to them being fearful and watchful at home.

5.18 All of the professionals spoken to as part of this CSPR acknowledge the importance of taking opportunities to check in with young people in care about how they are, and that this could include a discussion about sexual abuse. Asking their opinion on current issues in the media or on a popular TV show is a good way to introduce the subject with teenagers, as is speaking to them about what advice they would give a friend who was being abused. The IRO remembers having a discussion about The Handmaid's Tale with the middle child and now wonders if she could have pursued the content of abuse of girls and women with her. The child told the review however that she would not have disclosed at the time, as she needed to be ready to speak out and wanted control over this. The younger child, however, believes she would have told if she had been asked by a trusted professional, and that they would have known that she was lying if she denied she was being abused.

5.19 More generally however, there is a need for more openness about sexual abuse in families. As stated in Making Noise[13] there is a need to challenge the 'cultures of silence surrounding child sexual abuse' and that the more we speak about sexual abuse, the safer children will feel about disclosing. Schools are well placed to be a part of this cultural shift to more open discussion, as well creating environments where children know who they can talk to and what will happen if they tell someone. The middle child said that she had almost told one of her A-level teachers following a discussion about domestic abuse, as she felt he would believe her. She did not think the time was right, however. The youngest child told the review that she wanted to tell her female carer and almost did a number of times. She felt conflicted however about the impact it would have on the woman she loves and calls 'Mum'. This is a known barrier to disclosure for children being sexually abused.

5.20 The NSPCC report 'Child Sexual Abuse: Learning from Case Reviews'[14] states that professionals should 'take the time to build a consistent, stable, and long-term relationship with the child. This includes talking to children away from parents and carers and fostering an environment where children feel safe to talk.' Case reviews show that children in care often experience multiple changes of professionals, including their social workers, Independent Reviewing Officers (IRO) and those providing therapeutic interventions. This was not the case for the children considered by this review. There had largely been consistency while the children had been in the care of the local authority. They have had two IROs. They have had one social worker with the exception of one temporary social worker for around a year while their social worker was on maternity leave[15].

5.21 The foster carers had just two supervising social workers from their IFA during the course of the placement. The review was told that all handovers were well managed and that information sharing,

[13] Children's Commissioner (2017) The Making Noise research project focuses on children and young people's views and experiences of help-seeking and support after child sexual abuse in the family environment.

[14] Child sexual abuse: learning from case reviews - Summary of risk factors and learning for improved practice around child sexual abuse. NSPCC January 2020

[15] The eldest child has had a recent change of social worker due to her age.

and introduction meetings were prioritised. Reflecting on the support provided by the IFA and the local authority, the female foster carer told the review that she has been well supported, that supervision was regular and helpful and that she attends regular training. The only gap she identified was that she had never had any training on intra-familial sexual abuse. She gained a lot from training provided about sexual exploitation, but the focus was on the risks from outside of the home and she had very little understanding about sexual abuse in the home prior to the allegations being made.

5.22 The children regularly saw trusted adults at school, from the fostering agency, their social worker, their IRO, and health workers such as a consistent child in care nurse who undertook their annual medicals in the home. A NSPCC and University of York study[16] published in 2014 stated that children in care need a professional they can talk to and have access to when required, and that 'visiting children, listening carefully to what they say and spending some time with them away from placements are of fundamental importance' as is communication and information sharing between agencies. In this case there is evidence of good relationships between the children and the professionals around them, and many examples of them being seen alone outside of the placement. Two of the children were actively involved in the Children in Care Council and met a number of professionals outside of their allocated workers due to this. They also all received care from consistent respite foster carers that they developed good relationships with, and positive contact with the female foster carer's extended family members who provided support to the children and the carers as required. There was some learning identified by the individual IRO about the need to ensure that a respite carer's information is sought directly by them prior to the child's review. This would enhance practice. However, the IRO reported having a good sense of the respite placements being a positive experience for the girls and it is now known that the respite carers had absolutely no concerns about the children in respect of sexual abuse and were very shocked when the allegations were made.

Learning Points
Opportunities should always be taken by trusted professionals to have age and ability appropriate discussions about sexual abuse with children in care.
Schools are a key part of the system of providing a general environment where children know who they can talk to about sexual abuse and what will happen if they tell someone.
Foster carers require training on intra-familial sexual abuse.

5.23 There is no evidence of any significant impact on contact or the support provided to the children and the foster carers due to the Covid-19 pandemic. Face to face visits continued during the lockdowns, including from the youngest child's special school. She told the review how much she likes school and spoke about good relationships with trusted adults there. There was regular contact from agencies both virtually and directly and all statutory visits took place. Although the placement was long-term, consideration of less frequent visiting (lighter touch) from the children's social workers was dismissed as it was acknowledged that there were likely to be ongoing challenges and because the children voiced that they liked their meetings and visits from their social worker. This was respected.

5.24 The carers were subject to the IFA and the Local Authority's expectations regarding safer care, and this was checked with them regularly. The daily care plans that are agreed with foster carers take into consideration the need to ensure that children are safe, and this case was no exception. Both carers and the children regularly spoke positively about how the placement was working well. The agreed plans included one to one time with the male carer when he came home from work, something that was requested and apparently enjoyed by the children. As the girls grew older the daily care plans evolved and were formally updated and reviewed regularly. There was no indication to any of those involved that things were not as they seemed.

[16] Nina Biehal, Linda Cusworth, Jim Wade with Susan Clarke (2014)

5.25 In this case there was a significant amount of support from the IFA who built relationships with the children as well as the foster carers. There is evidence of direct communication with the children and meaningful contact from the IFA supporting social worker with the family and with the local authority social workers. The foster carers received good quality support and training, with reflective supervision and the support of a therapeutic specialist. The IFA reported that they successfully use dyadic developmental psychotherapy in order to help their carers understand the impact of abuse and neglect in their early years on children. This is said to be largely successful as they have a lot of long-term placements where children are meeting and exceeding expectations.

5.26 For the professionals involved, this case has been distressing and shocking. They had all seen the relationships within the placement as positive and healthy. None of them had any of the negative 'gut feelings' that professionals often describe when working with a family and sexual abuse later emerges. It was concluded that the perpetrator was extremely successful in grooming the children and the adults around them, including the experienced and skilled professionals involved. He also avoided detection for a considerable period of time. Sexual abusers will seek out roles where they have access to vulnerable children to abuse, as appears to be the case here. Those involved are aware that if it can happen in this placement, it can happen in any placement. The challenge following the review is how the Partnership can ensure that all professionals are aware of this fact.

5.27 The investigation into the allegations was timely and thorough. Both of the children and the female carer spoke about the difficulties but also the support they received. The carer shared the difficulty in being the non-abusing carer/parent and how difficult it was to get information and explanations, as the family were not entitled to a police service Family Liaison Officer in these circumstances. The review agreed that this would be shared with Wiltshire police for their consideration and a recommendation has been made.

Learning Points
Children in care in long term placements need significant relationships with professionals and/or their carers if they are to disclose sexual abuse, but even then, many children do not disclose their abuse.
Consideration should be given to how support and information is provided to families when there is an on-going investigation into abuse in the home.

6 Conclusion and recommendations

6.1 The rapid review meeting that was held shortly after the allegations were made felt strongly that a CSPR was required in this case due to the children being in the care of the local authority and the extensive contact they had with professionals for the nine years that the abuse had been happening. This CSPR has found good practice across agencies in how they worked with the children, the carers and each other, and that there were no indicators prior to the allegations made that the placement was not safe. The review has also found good practice that often went beyond that which is expected and has seen a high standard of care from the female foster carer.

6.2 Much of what was found in this case was not *new* learning, but this is a good opportunity to highlight what was found here in order to raise awareness and provide points for discussion amongst professionals in partner agencies. It shows how devious and manipulative perpetrators of sexual abuse can be and the need to provide every opportunity for children in care to be able to speak about what is happening to them, while also being aware that they may not disclose. This will involve a culture across all agencies of awareness that sexual abuse happens and the knowledge that while this area of safeguarding is complex and that not all children will disclose, many will if the opportunity arises. The younger child in this family was clear that she was looking for the right moment to speak out.

6.3 There has been meaningful cooperation with this review from the partner agencies and those involved with the family who had a wish to learn from this distressing case. The children continue to receive good care and support with additional therapeutic interventions in light of the abuse and imprisonment of the male foster carer.

6.4 In Wiltshire there has been a focus on intra-familial sexual abuse and on improving awareness and practice in this area. There is a commitment locally to continue this focus as well as a parallel focus on exploitation. CSPR Family N recommended that professionals are briefed about the way that perpetrators silence children when they are being sexually abused, and the patterns of behaviour of abusers. There is also a plan for this to be included in the SVPP workforce development programme and be used to inform the content of future planning. These briefings can now also include examples from the case being considered by this CSPR.

6.5 Having considered the learning stated above, the following additional recommendations are made:

Recommendation 1

The Partnership to consider how it can ensure that all professionals are aware of the learning from this review and the need for them to be thinking about and talking about the very real risk of sexual abuse of children in care.

Recommendation 2

The learning from this review should be shared with the Corporate Parenting Panel.

Recommendation 3

The Partnership to request that the learning from this review is used in foster carer training by the local authority and IFAs, including the need for training about intra-familial sexual abuse.

Recommendation 4

The Partnership to request that the Local Authority provides assurance of the plan to include direct information from respite carers in child in care reviews.

Recommendation 5

The Partnership to consider how they ensure that professionals are confident in safeguarding children from sexual abuse. This should include:

- Work with schools to consider how they can implement the recommendations from the Children's Commissioners report from 2017[17] to ensure that all children are aware that sexual abuse happens and what will happen when they speak to someone.
- Extend the work being undertaken on 'making every contact count' to include using opportunities to speak to children about sexual abuse.
- That support is provided to partner agencies regarding enabling professionals to feel confident about this area of safeguarding work.

Recommendation 6

The Partnership to ask Wiltshire police to consider the need for support for the non-abusing partner when investigating and prosecuting child sexual abuse cases.

Recommendation 7

The Partnership to consider whether they provide sufficient oversight and scrutiny of child sexual abuse.

[17] Preventing Child Sexual Abuse. The Role of Schools.