* Practitioners to be given adequate training on the indicators of CSA
* Professional Curiosity Training to continue to be made available
* RSB to continue to promote the national action plan on CSA
* LA school safeguarding teams to implement systems to review any patterns and trends associated with CSA, promoting CSA resources
* DPP to ensure any delays in providing antecedent information to sec47 processes are acknowledged at an earlier stage, and appropriate accredited companies are used for any DNA testing
* GP surgeries to consider implementing safeguarding flagging systems
* Opportunities to review and improve communication pathways between children and adult services to be explored

**Practice and Organisational Learning Actions**

A multi-agency judgement reached following the first referral and investigation in 2017 that the threshold to instigate legal proceedings was not satisfied prevented practitioners from seeking legal orders at this stage. This could have led to consideration of pursuing DNA testing without parental consent, which could have established the children’s paternity sooner. Working with suspicion of CSA without disclosure and complex family dynamics, combined with a genuine concern the family may move area if child protections processes were formally instigated, left professionals with difficult dilemmas and finely balanced judgments to make about how to achieve the best outcomes for the children.

**Professional Challenges and Dilemmas**

**Indicators of Child Sexual Abuse and Barriers to Disclosure**

The initial investigation gave a lot of weight to obtaining disclosures from family members. Research indicates evidence is broader than verbal disclosure and children are more likely to show us through behavioural responses they are being harmed. Barriers to disclosure include: the power and authority of the perpetrator; victim/survivor dependence on the abuser; violence and social isolation; all of which were factors in this case. Disclosure when it does come is a complex process and may not be a singular event. The [Centre of Expertise on Child Sexual Abuse Signs and Indicators Template](https://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/signs-indicators-template/) is a useful tool that can help practitioners working with suspected CSA.

**Identified Good Practice**

* Agencies acted swiftly at the point of disclosure, initiating both care proceedings and a criminal investigation resulting in adequate safeguards for the children
* Agencies worked together collaboratively in managing complex and concurrent criminal and family court proceedings.
* Professional curiosity and child-centred practice were both evident throughout the timeline and across all agencies
* Timely information sharing was evident across agencies
* The Welsh Government’s National Action Plan on CSA is embedded within the Regional Safeguarding Board region
* Support provided to the family throughout the legal processes and to the present day is noted to be exemplary

The victim and mother of the children went to live with her biological father and perpetrator aged 11. This followed years of childhood neglect and emotional abuse in which she witnessed violence and felt unloved and unwanted. She was a victim of her father’s predatory grooming and abusive behaviour when she was still a young and vulnerable child, and he abused his position of trust in an opportunistic way. Powerful coercive methods of control resulted in her inability to fully recognise herself as a victim, along with a belief that the perpetrator was not her biological father. Fear that to disclose would lead to losing her children prevented her from telling anyone what was happening to her over a number of years.

**History and Victim’s Lived Experience**

One of the victims and mother to the children has provided a significant contribution to this review, sharing her lived experience as a child, when the sexual abuse commenced, and her more recent experiences of living with her perpetrator and their children.

It is acknowledged with the benefit of hindsight and though a reflective multi-agency lens, indicators of sexual abuse were present over a number of years. This includes several known pregnancies before the age of 16 and the unknown identity of the father. Much of the learning and missed opportunities identified however is historical and falls outside of this region and the official time period being reviewed.

**The Review Process**

**Background**

In 2017, an anonymous referral was received alleging several children were born as a result of incest perpetrated by a father to one his daughters. Extensive multiagency enquires were undertaken which concluded evidence gathered did not support concerns raised. In 2018, one of the victims, aged thirty, made a further allegation to the police that she had been sexually abused by her father from the age of fourteen. Care Proceedings and a Police Investigation were commenced, leading to DNA testing confirming the perpetrator had fathered six of his other daughter’s seven children. The perpetrator was found guilty of repeatedly raping his 2 daughters and granddaughter and received a 40-year custodial sentence.

**CYSUR 4 2019**

**Extended Child Practice Review**