Southampton Safeguarding Children's Partnership

Children's Safeguarding Practice Review

Name: Uma

Date: 01.11.2023

SSCP

Child Safeguarding Practice Review

Learning identified from considering Uma

Contents

1 Introduction

1.1 The Southampton Safeguarding Children Partnership (SSCP) agreed to undertake a Child Safeguarding Practice Review (CSPR) to identify learning in respect of working with children who are vulnerable due to a history of being sexually abused in the family environment. To do so, consideration was given to the way that professionals supported a child, to be known as Uma[1], a 14-year-old who is in the care of Southampton Council.

1.2 The decision was made to undertake a CSPR after Uma was the victim of a serious incident. They left school during the day and later reported being raped. The perpetrator, who was previously unknown to Uma, has been convicted and sentenced.

1.3 Learning has been identified in the following areas:

- Early identification of those at risk of exploitation.
- The importance of seeking information about a child's history when they have lived in another area.
- Language used about vulnerable children.
- Retracted allegations.
- Impact on the child when professionals change.
- Responding to children at risk of exploitation when they go missing.

2 The Process

[1] Uma chose their own name for the review. They also wished to be referred to without a specific gender. They are white British and no specific learning has been identified in regard to their race and culture.

2.1 An independent lead reviewer[2] was commissioned to work alongside local professionals to undertake this review. She met firstly with Uma to draw up the terms of reference and to ensure that Uma's voice was prevalent from the start. Uma was keen to ask questions of those involved both at the time and during the review, and the questions they helped compile are attached as an appendix. Uma's views and powerful reflections are also included in this report where relevant. Uma hopes that the review will make recommendations to improve practice and systems in Southampton for children who are at risk of sexual abuse and exploitation. Uma was seen again at the end of the review and was updated on what was found and the recommendations. The lead reviewer and the panel thank them for their time and support of this process, despite it being difficult.

2.2 The detailed information and analysis that was provided by agencies during the Rapid Review process was used as a focus for the CSPR, and alongside Uma's questions it formed the basis for the terms of reference. Not all the agencies involved with Uma contributed to the Rapid Review but were engaged with during the CSPR and were given the opportunity to provide information and analysis.

2.3 A well-attended face-to-face multi-agency meeting with professionals involved in Southampton at the time was held. The session included detailed discussions about their involvement with Uma and reflections on the wider system.

2.4 A panel worked with the lead reviewer to identify the overall learning and recommendations included in this report. The panel also took responsibility for considering the single agency learning and improvement actions required, resulting in a single agency action plan.

2.5 Uma has very little contact with their mother but has an ongoing relationship with their father and at the time of the incident they were having regular contact with him. The parents have been informed about the review and invited to speak to the lead reviewer. They have not chosen to do so to date.

3 Uma's background information

3.1 There are clear indicators that Uma had a difficult early life and that they experienced abuse and neglect, including sexual abuse in the family environment. Both parents suffered with mental health issues and Uma was cared for at times within the extended family. The parent's relationship was also thought to be domestically abusive. The family had previously lived in another Local Authority area, and during this review information emerged about Uma's early years which indicates potential sexual abuse.

[2] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and entirely independent of the SSCP.

3.2 Following the parent's separation, Uma's mother had a partner who was a registered sex offender. When this relationship ended, she cohabited with her now partner and the father of her youngest child. Uma has made several allegations of sexual and physical abuse from the sibling's father, which resulted in Uma coming into the care of the Local Authority when they were nine years old.

3.3 While in the care of the Local Authority Uma has had several placement breakdowns. They have made allegations of physical abuse from carers in the past. Uma's on-going contact with family members is not straightforward and is regularly reviewed with Uma.

3.4 Uma has some history of self-harming and has been at risk of sexual exploitation on-line and in person.

4 Learning identified.

4.1 The learning identified for the safeguarding system and partnership is highlighted below, followed by detailed case specific and more general analysis.

Those working with children who are vulnerable to sexual exploitation recognise that there are likely to be early indicators of this risk and a need to ensure preventative work is undertaken.

4.2 Uma's experiences would have made them more vulnerable to being exploited than most of their peers. While it is known that any child can be exploited, there are those like Uma who are more vulnerable due to a history of child abuse, particularly sexual abuse. Professionals need to understand how much previous trauma increases a child's future vulnerability. The HIPS procedures[3] includes a helpful list of experiences that may mean a child is more at risk of sexual abuse outside of the family environment, which includes having a prior experience of neglect, physical and/or sexual abuse, all of which were evidenced in Uma's early childhood. Uma told the review that it was their view that any child who had been sexually abused from a young age would be more at risk of being groomed and abused again. They said 'It is what we know. We might even miss it.' This was a brave and insightful statement and important learning that needs to be considered when working with individual children and by the wider system.

4.3 Understanding a child's history is essential when considering risk as they mature. Information emerged during the review that was not known to those involved at the time, but this knowledge has provided a deeper understanding of the complexity of Uma's trauma. Uma had lived in another area pre-school, and there was knowable concerning information about their early years that required consideration. The information was found in Uma's GP records, which indicates the importance of seeking information from GPs. This is particularly crucial when it comes to children who have not always lived in the Local Authority area, as GPs may be the

[3] https://hipsprocedures.org.uk/qkyyoy/children-in-specific-circumstances/children-who-are-exploited#s4966

only agency that holds a consistent health history for a child that follows them wherever they live.

4.4 It is also known that children in care are more vulnerable to sexual abuse and exploitation. Uma's experience of placement instability would also have made them more vulnerable to exploitation. The HIPS procedures list of vulnerabilities includes children in care, particularly if they have had 'placement breakdowns' and/or the lack of a safe/stable home environment, now or in the past.' The procedures also include 'sexual identity issues' and 'the absence of a safe environment to explore sexuality'. For Uma their vulnerability in this area was known to carers and professionals and they were supported well. This included a concern that exploring these matters on-line may increase the risk of exploitation.

4.5 Research shows that children who are exploring their sexuality or who are LGBTQ+ may be at particular risk of sexual abuse, inside and outside of their family environment. This could, in part, be due to a lack of relevant relationship education, or them feeling confused and unsupported which may lead to them building relationships on-line. (Barnardo's 2016). This is an area of safeguarding work that requires skilled interventions and trained and knowledgeable professionals. The Independent Inquiry into Child Sexual Abuse published findings in May 2022, that LGBTQ+ children specific challenges which can increase vulnerability to child sexual abuse, with 'additional barriers making it difficult to disclose, access support or form adult relationships.' The inquiry quoted survivors who said they 'experienced confusion, frustration, or difficulty with understanding their own sexual orientation or gender identity as a result of the sexual abuse. For many this was made much more difficult because of the myths, stereotypes and attitudes in society.' Uma was therefore increasingly vulnerable due to the need for support in respect of their questioning of their gender identity. Those involved recognised that Uma's history of abuse and trauma needed to be explored with them to enable them to understand the impact of this on their identity, alongside non-judgemental understanding and acceptance. The use of trauma informed practice was important, in recognising the impact on Uma of previous experiences on their on-going well-being, to build resilience and insight.

4.6 The early indicators that Uma was being exploited emerged when they were living with a foster carer they liked and trusted. Uma had been accessing internet sites where they were targeted over the summer holidays before the start of year 8. Research suggests that online child sexual abuse can have as much of an impact on a child as abuse that only takes place offline and can lead to the same psychological difficulties (Hamilton-Giachritsis et al, 2017)[4]. For a child like Uma, who had experienced sexual abuse, on-line harm was likely to be particularly

[4] 'Everyone deserves to be happy and safe.' A mixed methods study exploring how online and offline child sexual abuse impact young people and how professionals respond to it. November 2017.

impactful. Plans were put in place to limit mobile phone use and to monitor who Uma was having contact with at school. The procedures that were used are explored further below at paragraphs 4.22 and 4.23.

4.7 Uma also had ongoing mental health challenges which increased their vulnerability. This included them discussing their feelings with friends 'online'. This led to them being targeted by exploitative adults, who used grooming techniques by showing concern, being understanding, and keeping in contact to 'check' on how Uma was after they had shared that they had self-harmed. The police have access to information from Uma's phone that these communications became exploitative, and Uma themself told the review how quickly they were targeted and abused in the on-line setting.

The language used in records about children and young people who are or have been sexually abused, including through exploitation, always needs to reflect that they are children who are being abused.

4.8 The above mentioned national independent inquiry into sexual abuse reflected on many years of systems and practice that did not protect children from abuse. While there have been improvements in the system, there was learning identified about the use of language by professionals in respect of the victims of abuse. While Uma was largely supported and protected, there were concerns identified about some of the language used to describe them in records and meetings. For example, that they were 'putting themselves at risk.' Victims of sexual abuse and sexual exploitation should never be held responsible for the harm they have experienced. Learning has been identified in many reviews about professionals using language which unintentionally implies that the child or young person was responsible for what happened to them, either through their own actions, or because of their existing vulnerabilities such as poor mental health. This may even mirror what abusers may say when grooming children. Children can then blame themselves and may not disclose their abuse.

4.9 In 2022 the UK Council for Internet Safety published a report entitled 'Challenging victim blaming language and behaviours when dealing with the online experiences of children and young people'[5]. While the report is aimed at professionals in education settings, it provides an interesting and timely insight to all professionals regarding the need to 'think critically about their own or others' language and behaviour, its impact and the ways they should be challenged.' In 2022 the Children's Society also published a helpful document called 'Appropriate Language in Relation to Child Exploitation'. It includes a powerful video made by children. The document provides detailed advice for professionals for when they are speaking

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1104000/Victim_blaming_and_the_online_experiences_of_children_and_young_people_v3.pdf

directly with or discussing children, within their recordings and for training. There is also a need for those undertaking learning reviews like this one to consider what the document includes. It states that 'language implying that the child or young person is responsible in any way for abuse and crime that they are subjected to, must be avoided to ensure we safeguard them appropriately. It is also important to recognise that a child cannot consent to their own exploitation.'

4.10 In Uma's case there was a need for all the professionals involved to check and challenge themselves and others regarding any views that the child was 'attention seeking' or 'craving' the attention they received from those grooming them or exploiting them. There were also some references to Uma being manipulative, which showed a lack of insight into the impact of their experiences and could lead to negativity and bias in decision making. There is a need to continue to check and challenge language and assumptions when working with Uma going forwards.

4.11 A discussion was also held about whether the child was being 'adultified' by the professionals involved in responding to disclosures and allegations, however there was no evidence of this. When meeting with Uma as part of the review, their young age was apparent, despite their insight into the abuse they have experienced and the risks they continue to face. Uma told the review that it is important that children do not feel blamed for being groomed and abused. They likened it to adults being scammed online and losing lots of money, which is a very good analogy.

It is not uncommon for children who have been or are being sexually abused to make allegations and then retract them. This does not mean they are not being abused.

4.12 Behaviour is as important as words when it comes to children communicating that they have been sexually abused. In Uma's case there were concerns over the years about sexualised behaviour, their quick attachments to male carers or foster family members and on occasion their behaviour around them, their distress and worries about their younger sibling still living at home, and their sexually explicit creative writing. There is an over-reliance in safeguarding systems on a child disclosing sexual abuse, yet children are unlikely to make a full allegation, particularly when the perpetrator lives with them or has a close connection to the family. This is a complex dynamic, as children usually want to be loyal and to remain living at home.

4.13 Uma made allegations of sexual abuse from the stepfather on several occasions, but then either partially or completely retracted these allegations. Most of those involved believed them and knew that they were likely to be telling the truth. Uma told the review, however, that they thought professionals believed they had lied. This highlights the importance of explaining to older the children that while a criminal investigation may not progress, that what they said was

believable and that they can always say more or reinstate their allegations when they are ready. This should also be made clear to parents.

4.14 Working with child sex abuse is complex, as children are unlikely to make a full and outright disclosure of exactly what has happened to them. This can leave professionals in limbo as they know that evidence is required to take decisive action to protect a child and to prosecute an alleged perpetrator. In 2015 the Children's Commissioner carried out an inquiry into child sexual abuse in the family environment. The report[6] states that 'the most common form of child sexual abuse takes place behind the front door within families or their trusted circle' and states that only one in eight children who are sexually abused come to the attention of statutory authorities, and that children often do not recognise that they have been abused until they are older. A Joint Agency Targeted Inspection (JATi) followed the report and was published in February 2020. It aimed to consider how professionals worked together in cases of sexual abuse.[7] The JATi noted that the quality of criminal investigations of child sexual abuse in the family environment is sometimes poor, and that there is often a degree of concern from police and prosecutors about the credibility of the child witness. This means that perpetrators can continue to abuse children and that children like Uma feel disillusioned with the criminal justice system. This resonated for those working with Uma and with Uma themself.

4.15 In February 2022 Uma and their sibling made detailed disclosures to their foster carer about the abuse, including allegations that their stepfather incited sexual abuse by other men and seeing their stepfather sexually abusing another child. When visited by the police to discuss the possibility of completing a video interview, both children stated the disclosures were fabricated and that they wanted to return home to their mother. This was an incredibly difficult time for Uma, who was again traumatised by their mother's support of her partner and verbalised disbelief of her children. Uma's emotional well-being at this time was a concern, stating that they wanted to 'end it all'. The investigation into the allegations was not continued, and there was no referral to the SARC[8]. The review was told that there is likely to be misunderstanding among professionals, particularly police officers, that the SARC just provides forensic medical examinations. This is not the case. The service provided is more holistic, including emotional support and practical help to anyone who has been sexually assaulted, recently or in the past. A clear process/flow chart is available on the HIPS procedures website. This information should be included in the learning briefing being compiled in respect of this CSPR, as a reminder to all practitioners.

[6] Protecting children from harm: A critical assessment of child sexual abuse in the family network in England. 2015
[7] Multi-agency response to child sexual abuse in the family environment: joint targeted area inspections (JTAIs) 4 Feb 2020
[8] Sexual Assault Referral Centre

4.16 The police did not further investigate the disclosures made and then retracted and closed their investigation. Hampshire Police told the review that they can now see there was a level of detail provided in the allegations which warranted further attention and exploration, despite the retractions, and that consideration of a wider investigation and the seeking of corroborative evidence was warranted. During the Rapid Review meeting that considered Uma, it was agreed that this was a missed opportunity to explore **why** the children may have retracted and to investigate what they had initially shared. Following the Rapid Review meeting the investigation was reopened, an action that the CSPR supports.

4.17 The HIPS complex and organised abuse procedure is for cases where there is a possibility of 'abuse involving one or more abusers, and a number of related or non-related abused children.' The allegations made by Uma and their sibling should have fallen into this remit and consideration could have been given to holding a strategy meeting under this procedure. There was also a need to consider in detail the allegations made by Uma in the past and to compare them to the most recent allegations, to identify the new information provided. This is a time consuming and detailed piece of work, and those involved were focused on supporting Uma through the emotional impact of making the allegations and their mother's response.

4.18 Uma has consistently expressed concern for the youngest sibling, who has continued to live with the parents despite the concerns and allegations. Uma has also been distressed as the middle sibling has blamed Uma for them coming into care. Possibly the biggest emotional impact for Uma however was their feeling of rejection by their mother who had chosen to remain with her partner. Uma told the review that this is what made them feel saddest.

Children in care can feel that professional relationships are not important or meaningful to the professional, and often feel let down.

4.19 One of the questions that Uma wished the review to consider was 'is there an understanding of the impact on a child and their ability to trust when there are lots of changes of professional?' For Uma there have been numerous changes of professionals and placements. Since they came to the attention of Children's Social Care (CSC) in Southampton in April 2019, when aged 10, Uma has had seven different social workers. This inevitably has had an impact on relationship building and trust, and on the knowledge of the history and Uma's lived experience over the three to four years of agency involvement. Uma told the review of their upset about a social worker who left, stating 'I trusted her with my life and then she was gone'. They explained that while some key professionals would try to have a good ending with Uma, others left without saying goodbye. The current social worker has been allocated for two years however, which is positive for Uma. Another issue that upset's Uma is the fact that professionals get paid to work with them, and that there was no one important in their life who was there unconditionally

and without payment. (Uma added that they were aware of the fact that many of them don't get paid much, but that this was not the point!).

4.20 The impact of staff turnover is an issue that often emerges during CSPRs. In Southampton there has been a particular issue with the recruitment and retention of social workers. This was apparent in a recently published CSPR Ted, where the family and other professionals were frustrated by changes of social worker and lack of communication about them leaving and periods where there was no named social worker for Ted[9]. This is not just an issue for CSC, but also in the NHS and in organisations providing therapeutic interventions. Although there are improvements noted, particularly regarding the stability of the workforce in CSC. When the Building Resilience and Strengths[10] (BRS) therapist who Uma was seeing left, time and attention was given to the ending, but this was another loss. The national CSPR panel have highlighted this issue in their reports. Noting how 'high levels of vacancies and turnover, and high caseloads can make it more difficult for practitioners to sustain the direct work on cases to make an impact.' Staff turnover does not just have an impact on children and their families, but also on embedding learning from case reviews. For Uma, the impact of this issue is more basic. It means they struggle to trust those who wish to support and protect them.

4.21 Uma has had consistency of Independent Reviewing Officer (IRO). This was important with the multiple changes of social worker. While not involved in day-to-day planning, Uma knows the IRO well and both confirmed that they have developed a good relationship. Uma has contacted the IRO independently and requested help and advocacy. The importance of this and of having someone they never have to tell their 'story' to, is a strength and acknowledged as important to the child and in helping new professionals to understand the history and the child's timeline.

4.22 There has also been consistency of professionals in school and Uma's school place has been maintained despite placement moves, which is good and which Uma has appreciated. It has been difficult to provide placement stability due to Uma's needs emerging and then changing over time. Uma now has a consistent social worker and time was given to Uma to help them to explore their feelings and to recognise their needs, and they were fully involved in decision making about moving from living with a foster carer, with whom they have since maintained a positive relationship despite the move, to a very small and specialist residential unit that is thus far meeting their needs.

4.23 It was recognised that Uma required therapeutic input. Initially support was provided to the foster carer to enable their care to be trauma informed. There was a delay in Uma being able

[9] A recent Ofsted inspection has evidenced improvements. It also highlights strong practice around step up and down decision making. Ofsted | Southampton City Council

[10] A multi-agency specialist CAMHS service specialising in children with severe and complex emotional issues

to receive individual therapy via Yellow Door due to capacity issues at the service. Building Resilience and Strengths, who had been supporting the foster carer, responded quickly and flexibly, and provided Uma with sessions when the need for these was apparent. They adapted their input, and the review was told that the work undertaken was timely and of good quality. They understood Uma's general vulnerability but have identified learning in respect of earlier consideration of the risk of Uma being exploited.

There is a need for joined up and effective responses to children at risk of exploitation when they go missing.

4.24 Uma was not a child who was going missing from school or home on a regular basis. In July 2022 they left school and refused to meet their foster carer. They later entered a shop and stated they were a missing child. The police were called, and Uma was taken to the police station before being returned home. The response to this incident was focused on whether the foster placement continued to be viable, along with discussions with Uma about why they were unhappy and did not want to return home to the carer. It was explored with Uma where they had been while missing, but they were not felt to be at risk of being exploited while missing at this time.

4.25 It was around six weeks later that Uma was recorded as being at high risk of child sexual exploitation and was allocated a named police Missing Exploited Trafficked Officer (METO) who built a relationship with Uma and worked closely with CSC, the school and the foster carer. This was because they had joined Omegle, an on-line 'chat' platform that connects users with random other users from around the world. It emerged that Uma was particularly vulnerable on this platform, as they were sharing images with large numbers of men in the UK and abroad, who they perceived to be caring.

4.26 There was evidence of good and timely joint working between the police and Uma's social worker following the completion of a Child Exploitation Risk Assessment Framework (CERAF) report. A single point of contact for Uma was created within the police team and a marker was placed on the Police National Computer (PNC) which states 'at risk of CSE' and that 'safeguarding should be considered if necessary'. A risk management plan was also prepared. The plan includes identified actions for the police control room and the custody suite, a police bulletin slide to brief police officers of the risk to Uma, use of a child abduction warning notice (CAWN[11]) where required, and a marker was placed on the home address. The plan was to be regularly reviewed and modified, but its effectiveness would have been improved had it been shared with other agencies.

[11] A CAWN is a non-statutory notice that is issued when the police become aware of a child spending time with an adult who they believe could be harmful to them.

4.27 There are two further missing episodes during the summer holidays and there are further concerns about self-harm. Learning has been identified for the police about the grading of these missing episodes, which were graded as medium risk. This was despite an increasing number of occasions when the child went missing and Uma having recently been identified as a child who was at high risk of CSE. The medium risk grading was significant as it means that adequate attention was not given to tracing where Uma had been, to noting information that might be helpful for tracing them in future, and to the recording of the risk on police systems. The main learning in respect of this plan, and more generally in this area of work, is that any child who is known to be HIGH risk for CSE must be seen and recorded as HIGH risk when they go missing, whatever the circumstances. Hampshire Police are in the process of improving practice in this area, and a recommendation is made for an update on progress to be provided to the safeguarding partnership.

4.28 On the day that Uma was seriously sexually assaulted, a meeting had been held at the school between Uma, the social worker, the police METO and the school to discuss concerns about the risk to Uma on social media. Uma left the premises later, witnessed by the school staff, the METO and the social worker who remained on the premises. The foster carer was informed immediately, who was then in text communication with Uma, trying to encourage a return to school. The specific circumstances of the event meant that the 'missing' protocol was not felt to be relevant, firstly because the carer was in contact with Uma, and secondly because a police officer was already in attendance. There has been learning identified however, that a missing report should have been made formally to the police, by either the officer on site or the school. The school have also made a recommendation to have a regularly updated risk assessment for every child who is known to be at risk of exploitation. They told the review that they are now clear that their processes must always be followed, regardless of the individual situation.

4.29 The resulting police investigation was extremely effective. The perpetrator was located, charged and remanded in custody within nine days of the incident. The Police information shared with this review identified tenacious work completed by officers to identify the vehicle and arrest and charge the perpetrator, potentially preventing any other children from being abducted and assaulted, and to provide reassurance to Uma. The resulting criminal trial led to a conviction and custodial sentence. Uma was sensitively kept up to date on progress. Uma told the review that it is very important to them that they know **what is happening, in all areas, always.** They reminded us that this is their 'actual life' that we are talking about.

4.30 This CSPR has found a lot of evidence of positive multi-agency working, professional curiosity and persistence, with high levels of care to Uma most of the time from the agencies involved. When meeting with Uma and then the professionals involved, the review was made aware of

a number of more recent school exclusions for Uma, and this is known to increase an individual child's risk of exploitation. The national CSPR 'It Was Hard to Escape' Safeguarding Children at Risk from Criminal Exploitation was published in 2020. The report is clear that children who are excluded from school can be those most at risk from exploitation. A recommendation has been made, despite the exclusions being outside of the timeframe of the review.

5 Conclusion and recommendations

5.1 While learning has been identified, particularly from hearing Uma's voice and understanding their insight into professional practice and systems, there has been good practice identified and evidence of a group of professionals who were committed to Uma and who wished to keep them safe.

5.2 This CSPR has considered the learning from Uma's case and has identified learning that will be helpful for the wider system. This includes single agency learning that has been identified during the review and single agency recommendations have been agreed to address the need for the improvement actions found.

5.3 Other non-statutory reviews are being undertaken by agencies and in the multi-agency context in Southampton. It is important that the learning from Uma is considered alongside the learning from these reviews, to ensure a system wide consideration of how agencies respond to these vulnerable and complex children. The review was told that this would be ensured.

5.4 There has been excellent cooperation with this review from partner agencies, which was essential in establishing the learning from this case.

5.5 Having considered the learning outlined in this report, the following recommendations are made:

Recommendation 1

That the Partnership ensure that the learning from this review informs the other work being undertaken in Southampton on a similar theme.

Recommendation 2

That the Partnership ensures that all relevant partner agencies consider what can be done differently to ensure the early identification of children on a trajectory to exploitation and provision of multi-agency support and preventative/educative work.

Recommendation 3

That the Partnership raises with other HIPS safeguarding children's partnerships and agency partners the need for system wide support for practitioners in respect of good practice when working with children who are exploring their gender identity.

Recommendation 4

Hampshire Police to provide detailed feedback to the Partnership on the work being undertaken in respect of missing children.

Recommendation 5

That the Partnership asks agencies to provide information on progress and challenge in respect of the language used in respect of vulnerable children like Uma.

Recommendation 6

That the Partnership asks the relevant partner agencies to provide assurance regarding what is being done to prevent school exclusion for children who are at risk of exploitation.

Appendix 1

Uma's questions:

While not all of Uma's question have been included in the main CSPR report, they were all considered by the relevant agencies and in the event held with professionals. Uma has received feedback and is satisfied that they were robustly addressed.

- Do professionals understand that a child who has been sexually abused from a young age is more at risk of being groomed and abused again?
- Is there an understanding of the impact on a child and their ability to trust when there are lots of changes of professional?
- Do professionals understand that children in care may have a 'guard up' and won't necessarily be able to talk to them about things that are very difficult, and that pushing them won't help?
- Do professionals and carers understand the need of a child to talk about and remain in touch with carers who have cared for them in the past, and do they make sure this happens if the child wants it?
- Do professionals always give the child a real choice about who attends meetings with them, especially therapy sessions?
- Do professionals recognise and understand that it is important to take what a child says seriously? Do they recognise that the child may have insight into what is going on and what might be wrong?
- Do professionals know that even children who are showing behaviours that can be explained by their experience of trauma, might ALSO have a diagnosable condition such as autism?
- Do professionals always make sure the child is kept updated and knows what is happening in their life?
- Do professionals give children a real choice about when and where they see them?
- Do professionals recognise that everyone makes mistakes and can have a bad day, and not overreact?