



# **Children P Serious Case Review Overview Report**

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## 1. Introduction

- 1.1 This Serious Case Review is conducted under the statutory guidance of Working Together to Safeguard Children 2015 which states that a serious case review should take place where “the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.”<sup>1</sup>
- 1.2 This review is about Children P, a pair of siblings who resided with their maternal grandmother and her partner until July 2013, when the children became the subject of interim Care Orders and placed in foster care due to longstanding concerns of sexual abuse and neglect.
- 1.3 The guidance is clear that serious case reviews are a part of the learning and improvement framework that all local safeguarding children boards must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.
- 1.4 Reviews therefore must seek to:-
  - identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
  - understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
  - be transparent about the way information is collected and analysed; and
  - make use of relevant research and case evidence to inform the findings

## 2. Terms of Reference

- 2.1 The review timeframe spanned two key practice episodes, July 2009 to January 2011 (first period of child protection planning) and December 2012 to July 2013 (start of the second period of child protection planning), to when the children were made subject of interim Care Orders and became looked after. Where relevant information was known before the beginning of the timeframe, agencies were requested to provide a summary.
- 2.2 The following key lines of enquiry were identified to be addressed in the review to inform learning and practice developments.
  - Sexual abuse
  - Neglect

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<sup>1</sup> Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children 2015, page 75

- Domestic violence
- Alcohol and substance misuse
- Parental physical and emotional ill health

### 3. Methodology

- 3.1 Working Together 2015 allows local safeguarding children boards to determine their own process for a review. The Case Review Sub-Group of the Local Safeguarding Children Board commissioned an Expert Leads Panel to manage the review process. The Panel comprised of senior managers of the agencies providing services to children and families in the Local Authority and was independently chaired. All Panel members were independent of the family and casework. The role of the Panel was to assist the Independent Reviewer in considering the evidence and lessons that could be learned to improve practice, formulating the recommendations and quality assuring this report.
- 3.2 The Independent Reviewer and Author considered the combined chronology and spoke with relevant staff to consider in detail the chronology of events and key practice episodes to develop hypotheses for further exploration in the overview report.
- 3.3 The Expert Leads Panel comprised of:-

Independent Panel Chair	NSPCC
Senior Manager	LSCB
Senior Probation Officer	National Probation Services
Service Manager,	Unity
Safeguarding Children co-ordinator	Health On Call
Lead GP,	CCG
Senior Manager (Child Protection)	Children's Services
Detective Chief Inspector,	Police
Designated Nurse (Safeguarding),	CCG
Named Nurse, Safeguarding Children,	NCUHT
Associate Director for Mental Health	CPFT
Assistant Director Children's Services	Barnardo's

- 3.4 The individual chronologies were integrated into a single combined document. The following agencies provided a chronology:-

Children's Services
General Practitioner
Health On Call
North West Ambulance Service
Police
Probation
Health Visiting Service CPFT
School Nurse CPFT
School
Child Adolescent Mental Health Service CPFT
A&E University Hospital NHS Trust
Maternity Services NCUHT
Outpatients (Fracture Ophthalmology NCUHT
Children's Ward NCUHT
Barnardo's
Royal Victoria Infirmary Newcastle

- 3.5 In addition to the agency chronologies, representatives from the organisations that had a significant involvement with the family were requested to respond to specific lines of enquiry.

## 4. Independence

- 4.1 Safron Rose, Child Protection Consultant was the Independent Reviewer and Report Author. Iain McKay was the Independent Chair of the Panel.
- 4.2 Safron Rose is a full time Independent Child Protection Consultant and trainer providing a range of safeguarding services to multi-agency managers and practitioners across England and Guernsey.
- 4.3 Safron has over twenty five years' experience in child protection social work. She has been involved in a number of serious case reviews since 2010, chairing serious case review panels and producing overview reports. Safron has a Diploma in Social Work, a CQSW and she also qualified as a mental health social worker. She has held various operational and strategic roles and is a former Director at the NSPCC. Furthermore, she was a visiting lecturer at the Tavistock Centre.
- 4.4 Iain McKay is an NSPCC Children Services Manager. He manages three sexual abuse services for children and young people who are victims of

sexual abuse, sexual exploitation and children and young people who display sexually harmful behaviour.

- 4.5 Iain is a qualified social worker with twenty four years post qualifying experience working in the area of child protection in both the statutory and voluntary sectors in England and Scotland. He has been involved in a range of strategic activities since 2001, including serious case reviews and producing policies and procedures. Iain was involved in the HMI Probation on the “Inspections of the Work of Probation Trusts and Youth Offending Teams to Protect Children and Young People” along with others from HMI Constabulary and Ofsted. He also contributed to the Police College audit of child sexual exploitation cases in police forces in England.

## **5. Confidentiality**

- 5.1 Working Together to Safeguard Children 2015 clearly sets out a requirement for the publication in full of the overview report from serious case reviews. “From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.”<sup>2</sup>

## **6. Race, language and culture**

- 6.1 The parents of Children P are described as white British and they speak English. The children were born in England into a culture where alcohol, drugs, sexual abuse, neglect and domestic violence were all present and longstanding.

## **7. Family Involvement**

- 7.1 Given the time taken to conclude proceedings around this case, it was not originally possible for the family to contribute to the SCR. However, more recent developments have meant that the parents were informed in June 2017 that a SCR was being undertaken. Mother and father met separately with the Chair of the Panel and the LSCB Senior Manager in July 2017. Their comments are reflected within this report.

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<sup>2</sup> Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children 2015, page 79

## 8. Dissemination of Learning

- 8.1 The process to disseminate learning from this serious case review will be managed through the LSCB Business Group and supported by the relevant Sub-Groups.

## 9. Timescales

- 9.1 The Expert Leads Panel met on the following dates:-

26 April 2015  
6 July 2015  
17 December 2015  
29 April 2016  
17 June 2016

The Overview Report was ratified by the Local Safeguarding Children Board at its meeting on 29 November 2016 and a final meeting of the Expert Leads Panel was held to finalise the recommendations and action plan.

## 10. Family composition

- 10.1 Subjects in this overview report have been given the following anonymity:

Child 1	2007	Subject
Child 2	2009	Subject
Mother	1990	
Father	1975	
Maternal Grandmother	1968	
Maternal Grandmother's Partner	1975	

## 11. Background Information

- 11.1 This family was well known to a considerable number of agencies because of issues related to a serious history of inter-generational sexual abuse, alcohol and drug misuse, domestic violence and mental ill health. The children's mother was sexually abused when she was a child by a man known to her mother's partner at that time. The mother and her siblings had been subject to child protection plans during 2005 under the category of sexual abuse and neglect.
- 11.2 The mother was significantly younger than the father at the time of Child 1's birth in 2007. At that time there was a history of domestic violence in the

parents' relationship. Children's Services were involved with the family from February 2008 when concerns emerged about domestic violence between the parents, a lack of engagement with health professionals and the mother's parenting capacity. The social work files report that the mother was emotionally vulnerable due to her childhood experiences of sexual abuse. In addition the household was described as chaotic.

- 11.3 During her early years, Child 1 was provided some care by her maternal grandmother at her mother's request. This arrangement was viewed as a protective factor by the professional network.
- 11.4 During the period of the shared-care arrangement Child 1's grandmother was in a relationship with her partner whom she later married at the end of 2009. It was reported that he had mental ill health and problems with drugs and alcohol. The files also indicate that there were concerns relating to domestic violence between the grandmother and her partner, violence between her partner and the children's father and that grandmother's partner was a drug dealer and had been the subject of a sexual abuse allegation. The concerns surrounding grandmother's partner became more pronounced over time and eventually brought into question grandmother's ability to safely parent her grandchildren.

## **12. Significant events during the first period of child protection planning 2009–2011**

### **2009**

- 12.1 In January 2009 the grandmother told her general practitioner that she sometimes had suicidal thoughts. She was prescribed anti-depressants and in April 2009 the general practitioner referred her for counselling and the counsellor subsequently referred her to the psychotherapy team. At that time she was sharing the care of Child 1 who was aged twenty months.
- 12.2 Child 2 was born normal delivery in March 2009.
- 12.3 In April 2009 the children's father admitted that he had slapped Child 1 during an argument. He stated that he had a problem managing his anger and needed help. It has been verbally reported that throughout the review timeframe professionals identified that father had problems with his anger management for which relevant referrals were made. However there is no evidence that he actually received intervention for this issue.
- 12.4 In June 2009 the children's mother started a course of anti-depressants for post-natal depression. Later that month she was taken to Accident and

Emergency having overdosed on different illegal drugs including heroin and cocaine.

- 12.5 During the same month, Child 1 was seen by the general practitioner regarding concerns about her displaying sexualised behaviour with her dolls and brother; in addition she had marks on the tops of her thighs. The general practitioner made a referral to Children's Social Care and advised her mother and grandmother to report their concerns to the police.
- 12.6 Child 1 underwent a forensic medical examination but there was no evidence to indicate that she had been sexually abused. It was recorded that she had genital warts which could have been contracted during birth.
- 12.7 Both children were living with their grandmother in June 2009 as a result of their parents' drug taking and domestic violence. Their grandmother was so concerned about the environment in which the parents were living that she did not allow their mother to take the children home on one occasion. The matter was reported to the social worker and health visitor by the grandmother.
- 12.8 In June 2009 Children's Social Care referred the children's mother for counselling. The first appointment was August 2009.
- 12.9 An initial child protection conference was held in July 2009 when both children became the subject of child protection plans under the category of sexual abuse. The shared care arrangement ended as a result of the acrimonious relationship between their mother and grandmother. Consequently the children went to live with their maternal aunt and her partner on a temporary basis.
- 12.10 In August 2009 they returned to their parents care but the parents' relationship ended and the children returned to the care of their grandmother whilst their mother set up her new home. Their parents resumed their relationship later that year in November.
- 12.11 At the Review Child Protection Conference in September 2009, it was agreed that the children should remain the subject of child protection plans.
- 12.12 The children's mother began a detox programme in November 2009; however the treatment was terminated because she used illegal substances during her stay at the clinic and so she was discharged.
- 12.13 Also during November 2009, whilst in the care of her mother, Child 1 ingested her mother's addiction medication which she had obtained "on the street". Child 1 was taken to Accident and Emergency and discharged to her grandmother's care by written agreement with Children's Social Care. It was agreed that all contact would be supervised by a family member and that

grandmother would seek a Residence Order to provide stability to the children.

- 12.14 In December 2009, grandmother's partner was admitted to hospital following a deliberate overdose of prescription drugs.
- 12.15 During the course of the year there were two domestic violence incidents relating to the parents that were reported to the police. The second incident led to a MARAC<sup>3</sup> request. The request was reviewed by the Detective Sergeant in the Public Protection Unit who decided that the case did not meet the criteria for MARAC because the majority of incidents were verbal and no assaults had taken place. Mother was referred to Let Go<sup>4</sup>. The Police case was filed as *No Further Action* at that time.

## **2010**

- 12.16 At the beginning of January 2010, Children's Social Care discussed the case with the Local Authority Solicitor who advised that the situation should be considered at a Legal Planning Meeting in light of the grandmother's intention to apply for a Residence Order. At the Planning Meeting it was agreed that the Local Authority would support her application for a Residence Order as it was "a family arrangement for the children to live with their grandmother and there were insufficient concerns to support an Interim Care Order".
- 12.17 In February 2010 Child 2 was taken to the general practitioner's surgery where he was seen by a nurse who noticed a cut under one eye and a bruise above his other eye. His grandmother said that Child 1 had caused both injuries, which the nurse verbally reported to the social worker the same day.
- 12.18 The parents were referred to the Triple P programme<sup>5</sup> run by a local voluntary agency in February.
- 12.19 At the second Review Child Protection Conference in March 2010 it was agreed that the children should remain the subject of child protection plans, however there was a change in the category from sexual abuse to neglect. Their grandmother informed the meeting that she was not going to pursue a Residence Order because "she felt that the parents were making good progress".
- 12.20 At the end of March 2010 the children's mother and grandmother had a disagreement which led to the children returning to live with their mother on a

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<sup>3</sup> A Multi-agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

<sup>4</sup> The Let Go Service provides a range of services to individuals aged 16 and over, experiencing domestic abuse.

<sup>5</sup> The Triple P – Positive Parenting Program<sup>®</sup> is a parenting and family support system designed to prevent and treat behavioural and emotional problems in children and teenagers.

shared care basis with their grandmother. Following the change in living arrangements, Child 1's behaviour was noted to deteriorate, grandmother's partner began to drink heavily, and soon after their mother was reported to have relapsed and was using drugs again.

- 12.21 At the end of April 2010, Child 1 put her feet in hot water but her grandmother did not seek medical attention for her injuries. She sustained another injury to her foot in May 2010 and on that occasion she was taken to Accident and Emergency for an x-ray and treatment.
- 12.22 In July 2010 the health visitor sought advice from a worker at the Child and Adolescent Mental Health Service in relation to Child 1's sexualised behaviour. The matter was brought to the attention of the clinical psychologist who advised that there was nothing that the service could do due to the child's young age and the fact that there was nothing to substantiate that she had been sexually abused. The psychologist advised the professional network to use distraction and reward techniques to manage her behaviour.
- 12.23 At that time grandmother had separated from her partner due to his alcohol addiction and his statement that he no longer wanted to care for her grandchildren. However they soon reunited after a short separation.
- 12.24 The children remained the subject of child protection plans at the third Child Protection Conference Review in August 2010. The chair of the meeting expressed concerns about the children's living arrangements and "hoped that the court will closely examine whether grandmother can meet these children's needs".
- 12.25 A Residence Order was granted to grandmother in September 2010 with contact restrictions to the children's parents.
- 12.26 In November 2010 the Social Worker and Team Manager discussed the child protection plans in relation to the health visitor's concerns for the children. The planned parenting assessment as part of the child protection plans was cancelled in light of the Residence Order being granted.
- 12.27 During November 2010, grandmother's general practitioner expressed concern that she was not looking after herself in relation to her diabetes and that she was not following medical advice to the extent that she could lose her eyesight and experience kidney damage.
- 12.28 The child protection plans were discontinued at the Review Child Protection Conference in January 2011. Conference agreed that the children would remain in the care of their grandmother and their wellbeing monitored within child in need plans.

### **13. Significant events during the second period of child protection planning 2012–2013**

- 13.1 In December 2012, the health visitor contacted the allocated Social Worker to report her concerns about grandmother's ability to keep the children safe. Child 2 had been sent home from nursery the previous day having cut another child's hair on two separate occasions and he had hit another child with an object.
- 13.3 At the end of the month, maternal grandmother contacted Children's Services Out of Hours Team to report that Child 2 had been smacked, very hard by a male relative, leaving a visible hand print on his bottom. The Public Protection Unit was contacted but no further action was taken.
- 13.4 A Strategy Discussion was held at the beginning of January 2013 to assess the allegation of smacking and the long term, ongoing concerns about the children's safety and wellbeing in the care of their grandmother and her partner. The decision was made to undertake Section 47 enquiries which concluded that both children were at risk of significant harm and the case was progressed to an initial child protection conference later that month.
- 13.5 Following the Strategy Discussion, legal advice was given to Children's Social Care regarding concerns about the children in the care of their grandmother. The lawyer advised that there were sufficient concerns regarding the standard of care being provided, however reservation was expressed as to whether the care was good enough and the extent to which efforts had been made to engage the grandmother in working with Children's Services. The advice was to quickly complete a further assessment to strengthen the evidential base.
- 13.6 Later on in January 2013, Child 1 and Child 2 became the subject of child protection plans under the category of neglect. The Conference decided that grandmother's partner should leave the family home immediately and only have supervised contact with the children. It was agreed that a legal gateway meeting should be convened.
- 13.7 At the beginning of February 2013 Children's Services consulted with the local authority legal representative who advised that the threshold criteria were met and to proceed to a legal gateway meeting.
- 13.8 The health visitor spoke with the social worker in March 2013 which led to "the child protection plan tightened [sic] and family warned that any breaches will result in children being removed". Later on in March, Child 2 was reported to have an unexplained bruise that did not occur during his time at nursery. The health visitor and social worker were aware that grandmother's partner had been going to the family home and he had been seen with grandmother collecting the children from school and nursery.

13.9 At the Review Child Protection Conference in April the Social Worker expressed concern about grandmother's lack of capacity to meet the children's needs. Earlier in the month, Child 2 was taken to Accident and Emergency having trapped his leg under a see-saw. The meeting also heard that there had been multiple breaches of the safeguarding agreement. A legal gateway meeting was planned for the following week to consider whether the children should become looked after.

13.10 Toward the end of April, the Local Authority agreed to initiate Care Proceedings in respect of both children and at the beginning of July, Interim Care Orders were granted in respect of both children who became looked after with the Local Authority.

## 14. Significant events in the intervening periods of child protection planning

SUBJECT	DATE	INCIDENT	ACTION
Child 1 & 2	March 2011	Health visitor reported deterioration in circumstances since CP plans ended	Reported to social worker
Child 1	June 2011	Allegation of physical and sexual abuse by grandmother's partner	Reported to social worker who interviewed Child 1
Child 1	June 2011	Allegation that mother put a cigarette in her mouth and false nails on her hand which hurt.	Interviewed by social worker
Mother	July 2011	Concealed pregnancy	Interagency information exchange
Child 2	July 2012	Fractured tibia and fibula. 'Caught leg under see saw'.	Attended A&E x-rayed – fracture. Referred to out-patient clinic for follow up
Child 1	November 2012	Allegation of inappropriate sexualised behaviour.	School informed mother or grandmother. Information not passed to head teacher.

## 15. Analysis

15.1 This Review relates to events that occurred in a period in excess of six years. Over that period a number of multi-disciplinary practitioners and managers were involved with the family, many of whom are no longer employed by the respective organisations. Those who still work in the agencies are in different roles or cannot remember what happened at the time to inform case work planning and decision-making.

- 15.2 In addition, since that time, practice in the Local Authority has changed as a result of developments in national policy, legislation and in relation to several inspections. The latest inspection report published in May 2015 concluded that despite significant improvements in many areas, particularly safeguarding, Services for Children Looked After were inadequate. However, it should be noted practice in this case is historic and whilst the Local Authority remains under the spotlight, significant improvements have been made. Based on external scrutiny and validation from the Department for Education and Ofsted - there is overall satisfaction that the Local Authority is making good progress and that performance has improved across the full range of services.
- 15.3 Analysis of the key themes and circumstances surrounding the professional responses to the abuse and neglect experienced by the children is severely limited because the independent reviewer was unable to review relevant multi-agency child protection policies and procedures that were in place during the review timeframe as the documents were not archived and no longer exist. Consequently it was not possible to judge whether policies and procedures were followed and whether they informed assessment and decision making to safeguard the children's wellbeing.
- 15.4 The Reviewer did however consider research from the review period to make a judgement about what would have been good practice and what would have been reasonable to expect in terms of effective inter-agency child protection interventions in relation to the children's safety and protection at the time.
- 15.5 The combined chronology was approximately three hundred pages long and contained many entries that did not help to illuminate what and why things happened to the children and how professional decisions were reached. Much of the data related to the adults and illustrated the severe and chronic dysfunction within the family. It did not provide the Reviewer with an understanding of why certain decisions were made which in turn has had an impact on the ability to provide a detailed analysis of the events and decision making.
- 15.6 The Expert Leads Panel agreed that the analysis should focus on professional responses to the key themes of:-
- Sexual abuse
  - Neglect
  - Domestic violence - teenage intimate partner violence
  - Substance and alcohol abuse

## 16. How well did agencies respond to concerns of sexual abuse?

- 16.1 At the time of the initial investigation into Child 1's sexual behaviour, Working Together to Safeguard Children 2006 was in operation. That statutory guidance stated that "Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways."
- 16.2 The Children Act 1989 introduced the concept of significant harm as the threshold that justifies intervention in family life in the best interests of children. The legislation gave local authorities a duty to make enquiries to decide whether action should be taken to safeguard the welfare of a child who is suffering, or likely to suffer, significant harm.
- 16.3 Child Protection practice in 2009 focused on the following elements to identify and understand significant harm:-
- The nature of harm, in terms of maltreatment or failure to provide adequate care
  - The impact on the child's health and development
  - The child's development within the context of their family and wider environment
  - Any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family
  - The capacity of parents to meet adequately the child's needs
  - The wider and environmental family context.
- 16.4 There were a number of reports of Child 1 displaying sexualised behaviour from as early as June 2009 which were reported by her mother and grandmother to professionals who were working with the family. The day before the Interim Care Orders were granted and the children became looked after, the school reported an incident involving Child 1 whereby another child had seen her kiss another child "down below".
- 16.5 The initial medical examination in June 2009 concluded "negative" for sexual abuse. It is presumed that medical examination also considered the bruising that was seen on Child 1's thighs. However the subsequent Section 47 enquiry determined that "the initial concern that Child 1 could have been exposed to some form of sexual abuse was unsubstantiated; however her sexualised behaviour in a child of two is unusual and needs to be investigated

further". This led to the children being made subject of child protection plans under the category of sexual abuse, which was good practice as it was judged that Child 1 may continue to suffer, or to be at risk of suffering, significant harm.

- 16.6 At the same time as displaying sexualized behaviour, Child 1 also was suffering from genital warts and there were differing medical opinions as to the cause. There were also differing views about the causation of the sexualized behaviour. Such behaviour was at times attributed directly to the warts which were said to be itchy. Sexual abuse can have physical consequences for victims including sexually transmitted diseases.
- 16.7 The health professionals (named doctor for safeguarding, safeguarding nurse, health visitor, general practitioner, specialist paediatrician) were thorough in their enquiries in respect of the genital warts and sexualized behaviour; even though they were not conclusive in their findings. They highlighted the need to consider the child's behaviour in the family context and that the physical examinations did not rule out sexual abuse.
- 16.8 Given the extensive family history of sexual abuse, the genital warts of uncertain causation, and the ongoing sexualized behaviour of Child 1, which seemed at times to go beyond age appropriate masturbation (e.g. banging her genitalia with her doll, laying the doll on the floor and lying on top of it, rubbing her vagina on her brother's head and panting) it is concerning that in March 2010 at the second review child protection conference the category of abuse was changed to neglect.
- 16.9 At that point (whilst there was clearly evidence of neglect) the focus seems to have shifted from the worrying sexualized behaviour of Child 1 which was unaccounted for. There does not seem to have been continuing emphasis on why Child 1 was exhibiting sexualized behaviour from this point. The background of neglect was itself a considerable risk factor where there was a concern about sexual abuse, because of issues such as a lack of boundaries and inadequate adult supervision.
- 16.10 In view of the framework for practice (see 16.3 above) whilst physical examinations were no doubt important to rule out some obvious indicators of sexual abuse, given the other indicators in this case, for example the very significant family history and the ongoing and unusual sexualized behaviour of Child 1, it is surprising that the focus moved to neglect.
- 16.11 There is no evidence to indicate or confirm that there were any thorough enquires or assessment with the grandmother or the mother as to their understanding for why Child 1 was behaving as she was. Given the background of familial sexual abuse as revealed by the grandmother to professionals and her serious concerns about the environment in which the

children's parents were living, the absence of such enquiries is troubling. Such information may have illuminated the situation considerably and led to earlier interventions to effectively protect the children prior to their removal into local authority care in 2013.

- 16.12 Unlike physical abuse, there are often no clear signs that a child is being sexually abused and cases of sexual abuse may be difficult to identify in situations where neglect or other concerns are the primary cause for concern. There is evidence that these children may have been more susceptible to being sexually abused as a result of neglect and an unstable home life and it is not clear how or whether such factors were taken into consideration by professionals when working with the family.
- 16.13 Studies have shown that social workers are sometimes not familiar with age-appropriate, sexual behaviour in young children which is a benchmark for judging abuse.<sup>6</sup>
- 16.14 It has been known for a considerable time that sexual abuse happens most frequently within families and therefore professionals needed to be skilled and confident in identifying risk indicators including the dynamics of familial relationships in order to analyse the situation to inform decision making and plans.
- 16.15 In the context of Child 1's very young age and her overtly sexual behaviour, the genital warts and family history it is most concerning that the issue of sexual abuse appears to have "slipped off the radar" and was not robustly investigated and adequate steps taken to protect Child 1 and her sibling.
- 16.16 Given that mother and grandmother had both experienced sexual abuse, it is not known how their histories were taken into account in assessment of their abilities to keep the children safe.
- 16.17 Overall it is not known whether social workers and other practitioners working with the family felt equipped to recognise and respond to sexual abuse. That the focus shifted suggests that they were not sufficiently knowledgeable or confident in dealing with the issue and it is possible that managerial support and supervision was lacking in this particular area.
- 16.18 Statistics show that during the review timeframe, the numbers of children being made the subject of child protection plans for sexual abuse nationally had declined from earlier decades. The reasons for this were varied and could indicate *a)* the focus on child sexual abuse was less than it had been previously, *b)* the result of declining levels of professional understanding and

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<sup>6</sup> Child abuse and neglect in the UK today. NSPCC.

awareness of child sexual abuse. Ultimately these reasons may have been reflected locally.

## **17. How well did agencies work together to assess risk and safeguard the children in respect of alcohol and substance misuse?**

- 17.1 “Substance misuse by a parent or carer is widely recognized as one of the factors that puts children more at risk of harm. The biggest risk posed to children is that parents, when under the influence of drugs or alcohol, are unable to keep their child safe.”<sup>7</sup>
- 17.2 *Hidden Harm*<sup>8</sup> identified that 54% of children of drug users did not live with their parents and most were placed within the extended family, usually with grandparents, which may cause a number of difficulties, which can include financial hardship, isolation and poor physical and emotional health. This was the experience of Child 1 and Child 2.
- 17.3 Good practice in this case would have required that assessments relating to drug and alcohol misuse in respect of the parents and grandmother’s partner should have included a thorough analysis of how their substance misuse posed a risk to the children. In addition the other known risk factors of parental emotional and physical ill health and domestic violence should have been examined in relation to substance misuse.
- 17.4 During the timeframe for the review, the Department for Education assessment framework would have been in operation and thereby all assessments in respect of this family should have been carried out with regards to the needs, safety and welfare of the children. The purpose of the assessment would have been to identify the impact of the drug and alcohol problem on the parenting capacity of the adults in the family, the environment in which they lived and the impact of its use on the children’s developmental needs and safety. It should be noted however that the reviewer has not seen any such assessments.
- 17.5 In the case of grandmother who was judged to be the main protective factor in the children’s lives and not an alcohol or substance misuser; her capacity to protect the children in view of her partner’s and daughter’s misuse also needed to be assessed. Professionals would have been aware that she was under considerable stress in view of her own difficult relationship with her partner and the tensions in her relationship with her daughter. Other than the referral for counselling and psychotherapy in 2009, it is not known what

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<sup>7</sup> Learning for improved practice around parents with substance misuse problems, NSPCC, 2013

<sup>8</sup> Hidden Harm, 2011

support she received to enable her to look after her own emotional and physical health and thereby have capacity to protect the children.

- 17.6 From the information received from drugs and alcohol services, the reasonable conclusion to draw is that during the first period of child protection planning, the assessments were adult / substance misuse focused with little attention to the impact on the parenting and the children's safety.
- 17.7 Research into substance misuse<sup>9</sup> (which relates to both drug and alcohol) highlighted that work with adults often focused on their individual needs rather than their role as parents. The immediate risks faced by children were often not prioritized, and necessary safeguarding action was not taken.
- 17.8 It is acknowledged that keeping children safe in cases of parental drug or alcohol use is a joint responsibility and is reliant on effective collaboration between agencies and practitioners that work with adults, children and young people.
- 17.9 In the second period of child protection planning there was more effective interagency working between drug and alcohol services and Children's Services which informed ongoing assessment and analysis which was more child-focused and therefore led to decisive intervention to initiate care proceedings albeit delayed.

## **18. How did professional understanding of neglect within the family impact on practitioners' ability to protect the children?**

- 18.1 "Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the family's strengths and supports".<sup>10</sup>
- 18.2 This is a case that was characterised by chronic and extreme neglect within a highly dysfunctional family system. All of the adults had serious emotional and/or physical ill health issues that made it practically impossible for them to prioritise and safeguard the children.
- 18.3 Neglectful parenting itself increases very significantly the risk of other forms of abuse, for example physical and sexual abuse, since such families are likely to be characterised by a lack of boundaries, poor adult supervision and little insight into the risks posed by others in the family. There is a danger that in categorising children as experiencing neglect, professionals fail to focus on

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<sup>9</sup> Hidden Harm, 2003

<sup>10</sup> Working Together to Safeguard Children 2006

the other risks they face that are heightened by the neglectful environment itself, which was the situation in this case.

- 18.4 Research shows that any child can suffer neglect, but some are more at risk such as children who live with a parent who:-
- has problems with drugs or alcohol
  - suffers from mental health problems
  - is in a domestically abusive relationship<sup>11</sup>
- 18.5 There is evidence to indicate that the myriad of adult issues overwhelmed not only the family but the hard-pressed, multi-disciplinary professionals involved who may have felt powerless to effect change in a family whose problems may have seemed insurmountable. Both mother and grandmother had unresolved traumatic histories which were compounded by ongoing familial substance misuse, alcoholism, domestic violence and poor physical health. Such was the complexity of the adult issues that the professionals involved did not or felt unable to effectively disentangle them.
- 18.6 It is reasonable to assume that the multi-agency practitioners would have received supervision during the review timeframe. However it is not possible for the independent reviewer to comment on the quality of those sessions for the reasons stated above in 15.1. The supervision process would have been a crucial mechanism in both supporting practitioners in the management of the case and in the developing their skills and knowledge in working with families with chronic multiple needs. In addition, good quality supervision would have provided space and the opportunity for practitioners to reflect upon the complexity of the situation and to receive emotional support from their respective managers.
- 18.7 Risk assessments should have evidenced that mother and grandmother lacked sufficient capacity to protect the children. That this was not realised sooner meant that the plans drifted, removal of the children was delayed and the children were not protected.
- 18.8 Further the professional focus on neglect meant there was a lack of focus of the level of danger for these children. Concerning incidents included the injuries to Child 1's feet in April and May 2010 which did not trigger timely and decisive action to adequately protect her, and there is a sense that professionals became tolerant and optimistic of the care given by grandmother and mother and applied a lower standard of care in the context of this very troubled family. The focus on the needs and challenges for the adults meant that risk assessment, analysis and decision making was not child centred.

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<sup>11</sup> Preventing child neglect – NSPCC 2015

- 18.9 It is difficult to understand why the matter was not put before the court sooner than July 2013 which may have led to the children being removed earlier for their safety and protection. Even if court proceedings had not resulted in removal they may have served to consider the evidence and or assess the parenting before the court with a supervision order or no order.
- 18.10 In the intervening period from the end of the first child protection planning to January 2013 when the children were again made subject of child protection plans; there appears to have been a *wait and see/what else needs to happen* approach when the underlying picture of the family circumstances was intractable and not amenable to positive and sustained change. There was a longstanding, ongoing high level of risks to the children and evidence that they had been suffering significant harm.
- 18.11 It seems that there were quite sufficient concerns to bring the matter to court in 2011. However it was a series of incidents from December 2012 that finally led up to the decision to initiate care proceedings in April 2013, these being:-
- Child 2 being sent home from nursery having cut another child's hair on two separate occasions and hitting another child with an object.
  - Child 2 being smacked very hard by his mother's partner, leaving a visible hand print on his bottom.
  - Breaches of the child protection plan by grandmother and her partner who was advised to leave the family home
- 18.12 It is apparent that these events were *more of the same* and a continuation of similar parenting provided during 2011. The incidents however coincided with the allocation of a new health visitor whose involvement in December 2012 brought a *fresh pair of eyes* and her presence in the multi-disciplinary network had the effect of galvanising attention on the children
- 18.13 From December 2012 it then took over six months to bring the matter to court. There were a number of meetings and local procedural requirements during which time the children remained in the home and the risks and harm continued. There should have been a mechanism to bring the matter to court as a matter of urgency.

## 19. Granting of the Residence Order

- 19.1 Following the time when the local authority was supporting a Residence Order to the grandmother in November 2009, there was a delay of ten months before it was granted; during which time there were a number of concerning incidents including:-
- Deliberate overdose of prescription drugs by grandmother's partner

- A facial cut and bruise on Child 1 inflicted by Child 2
- Breakdown in the relationship between grandmother and mother which resulted in the children returning to live with their mother
- Following the change in living arrangements Child 1's behaviour deteriorated, grandmother's partner began to drink heavily, and mother was reported to have relapsed and was using drugs again.

19.2 Such events should have strongly indicated that such an order was not in the children's best interest at that time.

19.3 It is reported that the local authority was not aware of grandmother's application to the court despite the allocated social worker and other professionals being involved in the lives of the children. It is puzzling why the court would not have sought a Section 7<sup>12</sup> report from the local authority given the substantial professional involvement with this family. That the local authority was not aware of the hearing demonstrates at the very least a breakdown in communication and a lack of proactive enquiry regarding the order on the part of social workers.

## 20. The Core Group

20.1 During the two periods of child protection planning the core group met on twenty four occasions (nineteen times during period one and five times in period two).

20.2 Statutory guidance requires that a core group is central to effective child protection planning. It is the purpose of multi-disciplinary professionals to meet regularly to develop, implement and crucially to monitor the plan's progress within an agreed timeframe to avoid drift and delay. This is the shared responsibility of all group members.

20.3 In view of the inaction of the core group despite regular meetings, it is likely that its function in this case was primarily to act as a support group for the members who were dealing with the overwhelming problems and dysfunction of the adult family members. In the case of Child 1 and Child 2, it is questionable whether those in attendance at the core group effectively examined, updated and implemented the detailed plans.

20.4 Furthermore, the reviewer has not seen the case conference outline plans and therefore cannot comment on whether these were clear, specific and outcome focused. Studies show that when conferences are well structured, they are more effective and lead to outcome focused plans.

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<sup>12</sup> Under Section 7 of the Children Act, the court can request CAFCAS or local authorities to provide reports to the court in respect of the welfare of the child

- 20.5 Information submitted to the reviewer confirms that relevant agencies and the parents attended core groups, meetings were held within the required timescales and were chaired by a social worker; all of which was good practice. There is evidence that key information was shared. For example:-
- Genital warts and Child 1's sexualised behaviour;
  - Substance misuse and the children's supervision in relation to this;
  - Domestic abuse;
  - Children's health and development;
- 20.6 However, it is not known whether actions arising from the discussions were recorded and disseminated so that those attending the meetings understood what they should be doing and by when, so as to achieve the desired outcomes for the children.
- 20.7 Despite all of the above factors being known the case history suggests that the core group was ineffective in that, decisive action was not taken to safeguard the children at an earlier date than when the children were finally removed from their grandmother's care.
- 20.8 It is a key function of any core group to track the progress of an individual child, including their wishes and feelings, which include observations of younger children. The inaction in this case leads to the inference that the group did not sufficiently scrutinise and pay enough attention to the specific needs of the children.
- 20.9 The consistent use of chronologies was not practiced in the local authority during the timeframe of the review; however the core group could have used a *Critical Incident Chart* which if used correctly would have fulfilled much the same function as a chronology, and may have assisted the group to risk assess and analyse the impact of significant events on the children's safety and wellbeing; and thereby remain child focussed.
- 20.10 Review and analysis of the numerous critical incidents would have been essential to achieve a fuller picture, an understanding of the impact of events and any emerging pattern of risk or concern. Such information would have evidenced an accumulation of needs and risks requiring a more timely multi-agency response.

## 21. How did professionals assess and respond to domestic violence in the parental relationship to safeguard the children?

- 21.1 Working Together to Safeguard Children (HM Government 2006) for the first time, formally acknowledged the need for professionals to protect children from harm arising from abuse or violence in relationships between children.
- 21.2 There was fifteen years difference in age between the children's mother and father. Research evidence has shown that a significant age differential in individuals greatly increases inequalities in intimate teenage relationships. Furthermore, girls in such circumstances have experienced multiple forms of violence from an older partner<sup>13</sup>. At the time of Child 1's birth in 2007 there was a history of domestic violence in their relationship. Mother was known to be vulnerable due to her childhood maltreatment. All of these issues should have been significant risk assessment indicators. Whilst the children were cared for on a shared care basis, it is not known how the risks associated with domestic violence in their parents' relationship were taken into consideration.
- 21.3 It is inevitable that the children would have been aware of tensions in the home even if they did not witness any actual violence, which would have been distressing for them. Given this, it is not understood why it was considered that a shared care arrangement involving their parents was safe.
- 21.4 Furthermore, being pregnant is a known high-risk for the escalation of domestic abuse, which was the case in 2009 when mother was pregnant with Child 2. The referral to MARAC in 2009 was correct; however the decision not to convene a conference was unwise in the circumstances as it did not appear to take account of mother's vulnerability and the specific research findings. Sign-posting mother to a domestic violence service was good practice but inadequate in the absence of a robust, co-ordinated, multi-agency plan that recognised the high risk to mother and the children.
- 21.5 It is not known how the issue of domestic violence was monitored and the children protected from it during the period of shared care, given that the violence continued which would have exposed them to ongoing risk and harm.

## 22. Conclusion and Learning

- 22.1 This section will summarise and collate the main conclusions from the analysis and related key learning to improve practice in respect of each of the key themes listed at 15.6.

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<sup>13</sup> Partner exploitation and violence in teenage intimate relationships.

## 22.2 The preceding analysis concluded:–

In respect of agencies responses to concerns of sexual abuse:-

- a. The initial enquiries and investigations into sexual abuse led to the children being made subject to child protection plans under the category of sexual abuse even though the evidence was inconclusive, which was good practice. Health professionals highlighted the need to consider Child 1's sexualised behaviour in the context of the family history and recognised the limitations of physical examination.
- b. At the second review case conference it was troubling that the registration category changed to neglect and the focus on sexual abuse slipped off the radar and no further assessment was progressed in relation to this. Consequently the understanding of why Child 1 was exhibiting sexualized behaviour remained an unknown. Had further assessments been pursued, information may have been obtained that should have led to earlier interventions to effectively protect the children. The known background of neglect should have signified that the children may have been more susceptible to sexual abuse as a result of the neglectful home environment.
- c. The shift in focus from sexual abuse to neglect demonstrated a lack of knowledge and confidence in dealing with sexual abuse, which included recognising age appropriate sexual behaviour in young children as a bench mark for judging abuse.

### ***Lessons Learned***

- When a child protection plan category changes it is incumbent upon the conference chair to ensure that the new plan takes account of outstanding actions including assessments that have not been addressed within the previous plan.
- Practitioners and managers must equip themselves with up to date knowledge of child sexual abuse including age appropriate sexual behaviour in children.
- A history of sexual abuse must be taken into account in risk assessment to determine the carer's ability to keep children safe.

In respect of interagency working to assess risk and safeguarding in relation to alcohol and substance misuse:–

- d. Good practice should have required assessments relating to drug and alcohol misuse in respect of the parents and grandmother's partner to have included a thorough analysis of how their substance misuse posed a risk to the children and parenting capacity. In addition,

- parental, emotional and physical ill health and domestic violence should have been examined in relation to substance misuse.
- e. Overall, assessments appear to have been adult/substance misuse focussed with little attention to the impact of such issues on the parenting and children's safety.

### ***Lessons Learned***

- Parental alcohol and substance misuse assessments should be multi-agency to ensure child focussed practice and timely decisive interventions to safeguard children.

In respect of professional understanding of neglect to protect children:-

- f. This case was characterised by chronic and extreme neglect within a highly dysfunctional family system. The myriad of problems experienced by the adults made it practically impossible for them to prioritise and safeguard the children and appeared to overwhelm the professional network.
- g. The children were made subject of child protection plans under the category of neglect; however professionals failed to take into account other risks facing the children that were heightened by the neglectful environment.
- h. Risk assessment and analysis should have evidenced the lack of parenting capacity and in the absence of thorough assessment, plans drifted and there was a delay in decisive action to protect the children.
- i. The matter should have been put before the court sooner. Despite advice that the threshold was met for proceedings in January 2013, matters were then delayed until April that year. Given the seriousness of the situation there was an option, even when it was considered that the evidence should be strengthened, to put the matter before the court to obtain a supervision order or no order.

### ***Lessons Learned***

- Practitioners should consistently use chronologies to understand and assess the emerging pattern of risks over time.
- Risk assessment, analysis and decision making in cases of neglect must be child focussed.
- Multi-agency managers must ensure that practitioners receive good quality supervision which enables staff to provide effective support and interventions to families who experience complex multiple needs.

- Children's Social Care is reminded of the three key principles under the Children Act 1989 which inform child centred practice:-
  - i) *The welfare of the child is paramount*
  - ii) *Delay is likely to prejudice the welfare of the child*
  - iii) *The court shall not make an order unless to do so would be better for the child than making no order.*

In respect of granting the Residence Order:–

- j. The order was initially supported by the local authority however a number of troubling incidents preceded granting of the order, which should have alerted professionals to the fact that the order was not in the children's best interests. There seems to have been a breakdown in communication and lack of proactive enquiry regarding the order by social workers.

### ***Lessons Learned***

- Where private law orders are supported by a local authority, managers and practitioners must continue to assess whether the order remains in the child's best interest and should this position alter, timely action must be taken to inform the court of the revised position.

In respect of the core group:-

- k. Whilst it was good practice that core group meetings were held within required timescales, with good attendance from all key stakeholders; in view of the inaction, delay and drift in the safety and protection of the children, it is likely that the group's function was primarily to act as support for the multi-disciplinary professionals, who may have felt overwhelmed by the adults' longstanding, insurmountable problems. It is questionable whether those in attendance effectivity scrutinized, updated and implemented the child protection plans. Consequently the group was ineffective.

### ***Lessons Learned***

- Core group meetings are an essential part of the multi-agency child protection planning process and therefore multi-agency professionals must ensure that the child protection plan is implemented as a detailed working tool.

In respect of domestic violence between the parents:-

- l. The parent's relationship was characterised by domestic violence which was well known to professionals. There was a considerably,

significant age difference between mother and father which together with other issues should have alerted professionals to risks given that the children were cared for on a shared basis. It appears that professionals did not take account of the increased risk of domestic violence during pregnancy, and it was an error not to convene a MARAC in 2009.

### ***Lessons Learned***

- Practitioners should risk assess domestic abuse in teenage intimate relationships' to take account of factors such as: older partners, teenage parent's exposure to sexual, physical, emotional abuse and neglect.
- Where the victim of domestic abuse is a teenager under 18, all agencies should give greater consideration to convene a MARAC.

In addition to the learning on the key themes, there is an overarching theme whereby it would appear that professionals did not view the mother as a child and she was viewed as an adult in all assessments. When professionals are working with teenage parents under 18, consideration should be given to their needs as a child.

## 22. References

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