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FAMILY O

A SERIOUS CASE REVIEW

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1. INTRODUCTION

1.1 Family O, a family of seven children between the ages (now) of 14 and 6, was originally known to agencies in Norfolk between 2004 and 2011. The children lived with both of their parents, firstly on a travellers' site and then in settled social housing. There were recurring concerns about neglect and physical abuse of the children. Some of the children had Statements of Special Educational Needs. The father was known to have mental health problems and there was evidence of domestic abuse. There were a number of referrals and assessments but no substantial, continuing involvement by the local authority in Norfolk.

1.2 In 2011 the parents separated and the father, with all the children, moved to a travellers' site in the Southampton area. The father had grown up in a traveller family, and some of his relatives lived on that site. All the children were now said to be educated at home by the father, although he himself was unable to read or write.

1.3 There were some continuing concerns for the general welfare and safety of the children. Evidence then emerged that the children had been neglected, and abused by their father over many years. After this the children were initially cared for within the travelling community by relatives of the father but these arrangements were not successful.

1.4 Eventually all the children were brought into the care of the local authority in Southampton through the courts. The father admitted numerous charges of neglect, physical and sexual abuse and received a long custodial sentence.

1.5 As a result of these events the Southampton Local Safeguarding Children Board (SLSCB) decided that a Serious Case Review (SCR) should be carried out. That review was completed and published[1] in May 2014.

1.6 Prior to the initiation of that review there had been discussions between the SLSCB and the Norfolk Safeguarding Children Board (NSCB). It was agreed that the review in Southampton should be completed, using information from agencies in Norfolk as background material. The NSCB would then consider the Southampton review and decide whether they should take any action in Norfolk.

1.7 When the NSCB did so it was recognised that there was evidence that these children had been seriously abused and neglected while living in Norfolk. It was also recognised that there had been missed opportunities for agencies in Norfolk to identify and respond to that maltreatment. Appropriate intervention should have prevented these children from suffering many years of serious abuse.

1.8 The Interim Chair of the NSCB, Mr David Ashcroft, therefore decided on 12th May 2014 that there should now be a SCR in Norfolk. This is the

[1] Overview Report Southampton.pdf

Overview Report from that review. It should be read in the context of the previous report published by the SLSCB.

2. FAMILY COMPOSITION

2.1 The father, Mr A, is some seven years older than Ms B, the mother of the children. She was 17 years old when the first of the children was born, and had all seven children by the time she was 27 years old. The children are referred to throughout this report, in descending order of age, as Child 1 through to Child 7.

2.2 The mother was initially from Norfolk. This is where she met Mr A. and she returned to live in the county after leaving the family. Her parents live in Norfolk and did have some contact with the children when the family was in this area.

2.3 Mr A's brother, Mr D, has strong connections with the Norfolk area. One of his sisters, Ms C, who was later briefly to become the carer for the children, has lived in Norfolk. There has been no known involvement of the children with the paternal grandparents, who are believed to have died. There is believed to have been one brief contact with the maternal grandparents during the period under review.

3. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

3.1 The purposes of SCRs are set out in the government's guidance "Working Together to Safeguard Children" (referred to in this report as Working Together). They are to establish what lessons are to be learned from the case about the way in which local professionals and organisations worked individually and together to safeguard and promote the welfare of children:
"when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children".

3.2 The Overview Report from the Southampton review was written by Mr Kevin Harrington, an independent person with extensive experience in the conduct of SCRs. In order to provide continuity between the review in Southampton and this exercise the NSCB appointed Mr Harrington to lead this review. Further details are at Appendix A.

3.3 The NSCB constituted a panel (the Panel), consisting of representatives of the various services involved with the family, to manage and oversee the conduct of the review.

3.4 This is a review of events before 2011 when the family left the Norfolk area. All of the agencies involved have seen substantial changes to their organisational arrangements and working practices. Some of the agencies involved at the time, particularly in the National Health Service, no longer exist in the same form. The table below gives information about the range of agencies contributing to the review.

AGENCY	NATURE OF CONTRIBUTION
Norfolk County Council Children's Social Care services (CSC)	Information about social work services to the family
Norfolk County Council Education services	Information from schools attended by the children and from assessments of Special Educational Needs
Norfolk Constabulary	Information about police contact with the family
Housing services	Information from various organisations which were the family's landlords
General practitioners	Information from the family's GPs
Community health services	Information from health visitors and community paediatric services
Hospital services	Information from maternity and A&E services
Mental health services	Information from NHS mental health services

3.5 The government has introduced arrangements for the publication[2] in full of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. The Southampton report has already been published and this report has been written in the anticipation that it will also be published. Nonetheless some confidential information should not be disclosed. Consequently the information in the report is limited so as to:

1. take reasonable precautions not to disclose the identity of the children or family.
2. protect the right to an appropriate degree of privacy of family members.
3. avoid the possibility of heightening any risk of harm to these children or others.

3.6 Anonymised Terms of Reference for this SCR are attached at Appendix B. They are drawn from the statutory guidance contained in Working Together but they reflect the particular circumstances of this review, where there has been no recent involvement.

[2] See Working Together 2013

4. METHODOLOGY FOR THIS REVIEW

4.1 This has not been a traditional review where a range of agencies contribute detailed information which they have analysed and which is then drawn together and further analysed by a Panel and independent reviewers. The events are too old and, as indicated above, some of the agencies involved no longer exist in the same form.

4.2 Instead the Panel members gathered information from a range of sources using their judgment on the significance of that material. That material has been collated in the narrative chronology below. The Panel identified a number of challenges and concerns arising from that information and considered them, identifying service improvements that had been made or might now be made to ensure that those challenges were met.

4.3 The Panel then convened a meeting for practitioners and managers from relevant services. The material identified in the review was discussed and evaluated, and the outcomes from that seminar have been incorporated into this report.

4.4 The parents had not responded to invitations to contribute to the review in Southampton, and similarly did not respond when contacted by the NSCB about this review.

4.5 It was decided in Southampton that the children would not be directly involved in that review prior to its completion – some of them expressly said that they did not want to be involved. Others were judged to be too young or too damaged to do so at that time. This review received information from Southampton which confirmed that it would not be appropriate to involve them directly in this exercise, though it was encouraging to hear that all were settled and making good progress.

4.6 The fact that these children lived in a travellers' community is very significant. It made it easier for their father to abuse them and harder for that abuse to be identified and reported. General issues related to safeguarding children in travelling families were examined in detail in the Southampton review, and are not repeated here.

4.7 It also became very significant that these children, once in Southampton, were all said to be electively home educated. That was not a relevant issue when they lived in Norfolk as they were not home educated. However there are links between home education and the safeguarding of children from travelling communities and the Southampton report also comments on that.

4.8 This report therefore consists of

- A factual context and brief narrative chronology.
- Analysis of key issues arising from the review and the agencies' responses to those issues
- Conclusions and recommendations.

5. NARRATIVE CHRONOLOGY

5.1 Background

5.1.1 The earliest information about the family seen by this review dates from February 2004. They were moving between Norfolk and Wales, before settling in a travellers' site in Norfolk in the summer of that year. At that point they had four children. Health visiting records already reflected continuing concerns about domestic abuse of Ms B when the family had been living on another site in Norfolk in 2002. She had repeatedly denied this, while reassuring health visitors that the health and development of the children was good.

5.1.2 The first records of contact with CSC date from September of 2004. An Early Years Support worker, visiting another family, contacted CSC. She was concerned after hearing detailed accounts from other travellers of very serious domestic violence towards Ms B, and noting "frozen watchfulness[3]" in the children.

5.1.3 CSC judged that the threshold for their involvement had not been reached. Around the same time Ms B declined continuing contact with Health Visitors. She did so during a visit at which the HV felt intimidated and threatened by Mr A.

5.2 2005

5.2.1 In mid-2005 agencies again became involved. The two oldest children – now aged 5 and 4 were admitted to School 1 where it was immediately noted that Child 1's speech and development were significantly delayed. Around this time Child 5 was born and visiting midwives and a health visitor were concerned at Mr A's intimidating behaviour.

5.2.2 In July Mr A jumped from a bridge and sustained a number of fractures. He had been given antidepressants by his GP three days earlier and had not taken them.The jump was thought to be an impulsive act of self harm because of discord with neighbours. He was referred by his GP to mental health services.

5.2.3 Travellers' support staff, health visitors and education staff are said to have liaised extensively in efforts to help the family, particularly in supporting school attendance. However in September 2005 a HV received a report, from a travellers' education worker, of Child 4, aged nearly 18 months, being *"tied to the ground with reins with limited movement".*
No action was taken on receipt of this report.

[3] Abused infants often exhibit a state of "frozen watchfulness," that is, remaining passive and immobile, but intently observant of the environment. This appear to be a protective strategy in response to a fear of attack.

5.3 2006 - 2007

5.3.1 The family left the travellers' site in May 2006, moving to a small town nearby in mid Norfolk. The three oldest children attended a new school in that area, School 2, from June 2006 until the summer of 2007. This was shortly before the birth of Child 6. Ms B saw a Health Visitor in August and told her that she no longer wanted contact with that service. In the same month the family declined contact with Speech and Language Therapy services for Child 1. The school kept a "behaviour log" for Child 1 from late 2006 through to July 2007. Entries highlight concerns about obsessive tidying behaviour, aggression towards peers and siblings and inability to concentrate.

5.3.2 The first records of police contact with the family date from March 2007. There were disturbances involving groups of people gathering outside the home at night. A gunshot was heard. These events were related to a dispute involving members of the extended family. They did not lead to any continuing involvement by police but the events were routinely notified to CSC. Police were called to the home in similar circumstances a few weeks later.

5.3.3 In April / May 2007 CSC have records of a request for an assessment because of concerns about Mr A's mental health. Around the same time CSC were notified by a member of the public that they had seen a three year old child tied to a settee, a child tethered in the garden by a wrist restraint and of an incident where the children had watched a dog savaging a chicken. CSC carried out checks about the family background but took no further action.

5.3.4 In July 2007 the family's landlords, a housing association, received a call from a neighbour complaining about the behaviour of the children. The neighbour was told that agencies were trying to assist the family. Two months later there was a further complaint to the housing association, now raising concerns about the parents' treatment of the children. They were said to be locked in their rooms after school, urinating out of the windows and also standing naked at the windows. This was reported by the housing association to CSC.

5.3.5 This led to enquiries being made by CSC of School 2. The long-standing concerns about Child 1 were reported but at that point there were no reported concerns about Child 2 or Child 3. There is a record by CSC that the family would not consent to information being shared between agencies. A social worker is recorded as visiting but there is no further information about that visit. A few days after the visit CSC decided to take no further action.

5.3.6 In late 2007 the family moved to the south of the county, and the children accordingly changed schools again. Child 1 attended School 3 until the end of the year, moving then to School 4, possibly because School 4 had a specialist unit for children with learning difficulties. Child 2 and Child 3 attended School 5. The three children stayed at these schools until the summer of 2008.

5.4 2008

5.4.1 Child 7 was born in early 2008. At this time there were mounting concerns for the family. The children were said by neighbours to be uncontrolled. An anonymous referral to CSC described them as frequently crying, looking unhappy and emotionally drained. Midwives had been concerned about the hygiene in the home. Ms B had been seen with facial injuries. Mr A, talking to a midwife and health visitor, had three repetitive conversations in a short space of time suggesting that he had short term memory loss.

5.4.2 A meeting was held in mid-February. This was intended to be a Strategy Meeting under formal child protection arrangements but police were not invited, a fundamental requirement for these meetings. The principal outcome of the meeting was that there would be no immediate child protection investigations but social workers would conduct a Core Assessment[4].

5.4.3 There was then one lengthy joint visit by a social worker and a health visitor. The parents, the three youngest children and Mr A's sister, Ms C – who was to play a significant part in events after the move to Southampton – were seen. It was concluded that concerns were in fact insufficient to warrant a Core Assessment and that CSC would not take any further action. Records indicate that schools were contacted and reported no concerns about safeguarding or attainment. Soon after this the health visiting service reduced their contact with the family on the basis that they now needed only a "routine" service instead of the "high level intervention" they had previously aimed to provide.

5.4.4 During the early months of 2008 the family were the subjects of harassment because of their travelling background, with objects thrown at their home and explicitly racist messages spray-painted on the garage. Around this time neighbours again made a report, on this occasion to a health visitor, of concerns for the children who were said to be locked in and out of the home, often crying and in distress. The health visitor did not take any action on this matter except to suggest the neighbours contact CSC.

5.4.5 In August 2008 the family moved again, to West Norfolk, where the five oldest children were all enrolled at the same school, School 6. There was now the only period of sustained attendance at one school for the children. All those of school age attended School 6 until June 2011 when they moved away from Norfolk. The three oldest children were all now made subjects of Statements of Special Educational Need.

5.4.6 During 2008 Mr A was again referred by his GP to mental health services. He had reported feeling low and was diagnosed as having delusional psychosis, associated with religious beliefs. He maintained contact

[4] A Core Assessment (Framework for the Assessment of Children in Need, HMSO 2000) is a detailed assessment, undertaken by CSC over a period of weeks, when it is suspected that a child is suffering, or likely to suffer, significant harm.

with that service until 2011, having a total of 44 contacts with a range of staff including a psychologist and a psychiatrist. One of his sisters was also seen and disclosed that they had been seriously abused as children by their father, who regarded Mr A as "possessed". Mental health staff noted that Mr A had 7 children but did not liaise at any time with children's health or social care services. They also carried out a number of "risk assessments" and a Carer's Assessment of Ms B, but none of these assessments considered the possibility of risk to the children.

5.5 2009

5.5.1 In the first three months of 2009 there were seven attendances at A&E, involving 4 of the children. These were all for reported minor ailments or injuries. They did not give rise to any concerns at the time.

5.5.2 In April 2009 the family again came to police attention, on this occasion for concerns directly related to child care. Officers on patrol found the three youngest children unattended, two strapped into a pushchair outside the family home and one, also strapped into a pushchair, and in distress, inside the home. Both parents were found upstairs and appeared confused as to why the police were concerned about the situation.

5.5.3 Police routinely notified CSC of this contact and this led to two visits by a social worker in May. At the first visit the social worker noted that the house was sparsely furnished with all the children sharing two beds, and that the parents were not in control of the children, lacking any insight into the risks this posed. At the second visit, a week later, the social worker noted a significant improvement in the home conditions and felt that there was no need for continuing contact. Instead it was agreed that a family support worker would become involved to assist and support the parents in "providing more consistent and safe parenting".

5.5.4 The parents were clear at the outset that they would be *"happy when CSC involvement was over".*
In fact the contact effectively "fizzled out" in the face of a lack of engagement from the parents who would not give their consent to standard checks being carried out with other agencies. By the end of June the case had been closed by CSC.

5.5.5 Just before that, in mid-May, Child 4 was seen by a Consultant Community Paediatrician, referred by a School Nurse in respect of developmental delay. The doctor found that the child had multiple bruises, and documented these on a body map. The doctor was also concerned at the child's presentation, shy and whispering and focussed on his father who accompanied him. The doctor felt that there was a need for a child protection investigation and spoke to the social worker to request that these matters be investigated. The social worker visited the family that day, but decided that the

doctor's concerns were unfounded, and took no further action. No other agency was involved in this decision[5].

5.5.6 From late 2009 School 6 kept a detailed log of concerns for these children. They were all repeatedly presenting in school tired and hungry, reporting that they had not had breakfast as there was no food in the home. The school noted that a number of the children had injuries, the girls were particularly quiet and withdrawn and Child 1 was often seen to behave in a strange detached way. In mid - November a written referral was made, describing these concerns, to CSC, and referring specifically to injuries to one of the children noted earlier in the year. Soon after sending that letter one of the children was seen to have injuries to her bottom described by the school at the time as "round and scabby, like cigarette burns". (When the children finally came into care in Southampton there was evidence that they had been burned with cigarettes).

5.5.7 The Head Teacher contacted the parents directly, setting out a detailed schedule of concerns and then met with them. They were hostile and denied any cause for concern. All injuries were said to be caused accidentally or as a result of games and fights between the children. The children continued to present in much the same way and, on one occasion in December, one of them had injuries to his nose which he said were caused by his father punching him. The Head tried to ring the parents but could not get through. On the same day CSC responded to the written referral, made nearly a month previously, by writing back to advise that they did not think they needed to be involved and suggesting that a CAF[6] be carried out.

5.6 2010

5.6.1 In May 2010 the school made another formal referral to CSC, describing effectively the same concerns. By now a pattern had been established of parental non co-operation with the arrangements for meeting the older children's special educational needs. This referral was accepted by CSC and a social worker visited the home. The parents denied any cause for concern, saying that the children were adequately fed and arguing that having such a large family made it difficult for them to meet all the school's expectations.

5.6.2 The social worker judged that they had given adequate explanations for the concerns raised, and arranged a meeting at the school with the parents. It was agreed that the school and parents would try to communicate more effectively in future. CSC then closed the case.

[5] This incident is of particular concern and has been the subject of a separate management investigation by Norfolk County Council. The social worker is no longer employed by Norfolk County Council.

[6] The CAF was established by the former Department for Children, Schools and Families. It is a standardised approach to the early assessment of children who may have additional needs. The CAF is not appropriate to situations where there are child protection concerns.

5.6.3 In August Mr A changed the tenancy on the family home so that it was in his name only and it is now known that at this time Ms B had left the family, returning to live with her parents in another part of the county. Mr A did not disclose this but school staff noted that the children's presentation was deteriorating further and school attendance was becoming erratic. The new situation came to light in November when Mr A took all the children and left them with Ms B, saying that he could no longer cope with them.

5.6.4 Ms B contacted CSC but they did not become directly involved and it appears that by December she had returned with the children to the family home. The children returned to School 6 where staff and, increasingly, other parents noted that they appeared neglected and were often brought to school late by Mr A. The school made another referral to CSC.

5.6.5 A social worker made an unannounced visit but was refused access to the home. The social worker returned the following day, New Year's Eve, and confirmed that the home conditions were very poor. Cupboards and doors were broken, floors were uncovered and there were not enough beds and bedding. There were no toys in the house.

5.6.6 The social worker said that they would work with the family to assist them with their problems but refused a direct request from Mr A that the children be admitted to care. (It has not been possible to substantiate a subsequent claim by one of the children that they had directly asked to be admitted to care).

5.7 2011

5.7.1 The family was allocated to a social worker for long-term involvement. That social worker contacted the family at the end of January, but Ms B would not allow her into the home, saying that their problems had been resolved. The social worker persisted and Ms B then agreed that the family would accept a visit, by appointment, some two weeks later. At that visit, at which only the parents and Child 7 were present, the social worker was allowed access to most, but not all, of the house, which had been cleaned and smelled of bleach. The bedrooms were tidy and the beds were made but there were no floor coverings and again no toys in the home. The social worker felt that she had been able to persuade the parents that they should "work with" CSC, and that she would therefore visit on a monthly basis. A visit was arranged at which the social worker asked that all the children should be present.

5.7.2 That visit was cancelled by the family and rescheduled some two weeks later in March. The social worker saw both parents and the three youngest children. The older children were said to be out playing. The house was clean and the presentation of those children who were seen raised no concerns, though the social worker noted that Mr A was in a low mood and spoke of moving away from the area.

5.7.3 This proved to be the last contact with CSC in Norfolk. Ms B cancelled an appointment in April and it was learned in June that the parents had separated. Ms B was living elsewhere in Norfolk and Mr A and the children had moved to Southampton.

5.7.4 CSC closed the case without making a referral to their counterparts in Southampton or liaising with any other local agency. No arrangements were made by Education services to ensure that their counterparts in Southampton were informed – a statutory requirement for children with Statements of SEN.

5.8 Subsequent events

5.8.1 Details of subsequent events are set out in the Southampton report. Essentially, some two years after moving to Southampton it was established that all the children had been severely neglected, sexually and physically abused over many years by their father. Further opportunities to intervene were missed by agencies in Southampton.

5.8.2 On moving to Southampton the children were all withdrawn from school on the pretext that they were being home educated but in fact received no education at all. The special educational needs of the three “statemented” children were disregarded.

5.8.3 The mother of the children did not maintain contact with them after they left Norfolk, nor when they were brought into care. Some of the children reported that their mother had both been aware of the abuse and had physically abused them herself when the family lived in Norfolk. Ms B denied any knowledge of any abuse or neglect of the children but did not wish to have any continuing contact with them.

5.8.4 Southampton City Council has provided a report describing the current situation of the children, which is positive. That report has been shared, confidentially, with the headteacher of the school which they last attended, where many attempts had been made to assist them

6. ANALYSIS

6.1 Introduction

6.1.1This is a “historical” case review. The events took place some years ago and the children have not lived in Norfolk since 2011. There have been substantial changes to the way services are delivered and configured. It has often not been possible accurately to explore why staff and agencies acted as they did. Consequently it has generally not been appropriate to analyse events in detail. Instead the review has identified the key issues arising from these events and made recommendations reflecting those concerns.

6.2 Standards of safeguarding practice

6.2.1 There was substantial, repeated evidence of cause for concern for the safety and welfare of the children yet few child protection referrals were made. For example, in 2008 a Health Visitor took no action when told by neighbours of maltreatment of the children. In 2009 a teacher noted injuries to one of the children, who said they had been caused by his father, but the teacher took no action. Even School 6, which did the most helpful work with these children, tolerated a good deal of evidence of neglect.

6.2.2 This raises concerns that there was

- no clear ownership, across the agencies, of the need to identify and respond to these concerns
- a lack of clarity about when to make a child protection referral, and / or
- a view that a child protection referral might not successfully lead to action by CSC

6.2.3 There is evidence of particular cause for concern about standards of practice in CSC. They include:

- in February 2008 a concern was initially to be investigated under formal child protection arrangements, then as a Core Assessment and eventually became an Initial Assessment consisting of one visit.
- a social worker gave a school incorrect advice about the use of the CAF in 2009
- there were two occasions when a social worker visited, noted very unsatisfactory home conditions, and was then satisfied that the problem had been resolved at one follow up visit.
- There is little evidence of supervision of staff
- the paediatrician's referral in May 2009 was not followed up appropriately
- a social worker refused to consider the one request for admission to care in 2010
- the last social worker arranged to see the family on a monthly basis without any clear plan for what this would achieve
- the case was closed without appropriate liaison with Southampton in 2011

6.2.4 These issues were discussed throughout the review and at the multi-agency workshop held towards the end of this process. All agencies described a marked change in the situation in Norfolk since 2011, and particularly since very critical Ofsted inspections of CSC in 2013. Staff of other agencies reported a greater confidence and willingness to make referrals, judging that they would receive a more helpful response. Structural changes in CSC, moving from three localities to six, had been widely welcomed. An Institute of Professional Excellence had been developed to promote best practice. Standards of supervision have been raised so that work would be better targeted and more closely monitored.

6.2.5 Staff were enthusiastic about the “Signs of Safety” approach, a method of working with families which draws upon techniques from Solution Focused Brief Therapy (SFBT). This approach is now being introduced in Norfolk. It sets out to work in partnership with families and children to assess risk and increase safety by focusing on family strengths and resources.

6.2.6 Overall, staff of all agencies reported a drive to raise standards and make a difference to the children and families of Norfolk. Nevertheless this review must respond to the concerns it has identified and there is accordingly a recommendation that these reported improvements be audited and confirmed.

6.2.7. There is, in the information seen by this review, no evidence of any supervision of staff, or management ownership of the recurring concerns. This is not just an issue for CSC – there is also clear evidence of staff in other agencies responding inappropriately to concerns but of this not being picked up in management and supervision arrangements. Within CSC there was, on the contrary, such a drive to close cases that the management of work had become rushed and unsafe.

6.2.8 Reliable supervision arrangements are as fundamental to good safeguarding practice as assessment and decision-making. Again the Panel heard that the situation in CSC is now much improved but the Board will want to satisfy itself on that issue, and to see evidence of good practice in the scrutiny of case management and the supportive supervision of staff across all the agencies. That will need to take account of differing governance arrangements and cultures for supervision. There is therefore a further recommendation on this point.

6.3 Domestic abuse

6.3.1 Ms B was extremely violently abused by Mr A throughout their time together. The enduring damage this causes to children is well evidenced and features repeatedly in SCRs.

6.3.2 She did not disclose this to staff of any agency but it is right to question whether agencies were sufficiently alert to this issue and whether more could have been done to engage Ms B. Staff, particularly from police, have reported sigificant changes in their work with victims of domestic abuse. The approach has become more pro-active with resources directed towards good risk assessments, informed by collaboration across agencies to share information. Police are aware of the particular difficulties in responding thoroughly to domestic abuse in traveller families and are working with those communities to develop appropriate “ways in” to the problem. Again there is a recommendation seeking confirmation of improvements in the awareness and responses of all agencies.

6.4 Special Educational Needs

6.4.1 It was a considerable achievement to get three of these children through the "statementing[7]" process in the face of parental non co –operation and hostility. School 6 reported that they pursued this relentlessly because *"the needs of the children were greater than the difficulties posed by the parents".*

6.4.2 However, when the family moved from Norfolk the fact that three of them had statements of Special Educational Need was not formally notified to the education authority in Southampton. The Southampton SCR expresses concerns about the way this was managed by education officers in that area but the principal statutory responsibility rests with the authority which the family are leaving. There is no evidence that this was anything more than an isolated incident but it was significant and leads to a recommendation from this report.

6.5 Working with travelling families

6.5.1 The fact that this was a travelling family was a major issue in Southampton. The father exploited their "separate" status to abuse the children with less probability of being found out. The closed community tolerated repeated evidence of the abuse and neglect of the children before referrals were made to child protection agencies.

6.5.2 There is some evidence of similar issues from the time in Norfolk and also evidence, in 2008, of harassment of the family because of their travelling background. However, for most of the period under review in this report the family lived in settled accommodation and, for example, school staff were not even aware of Mr A's travelling background.

6.5.3 The Southampton SCR deals in detail with broader issues relating to the safeguarding of children from travelling families. That material is therefore not set out again in this report. However the first recommendation from the Southampton SCR, which relates to raisng awareness of safeguarding issues for children in travelling families, is relevant and also appears as a recommendation from this review.

6.6 Adult mental health services

6.6.1 Mr A had a period of surprisingly substantial contact with mental health services, given his hostility to the other agencies. However mental health services did not liaise at all with children's services and showed no alertness to the needs of the children of the family. The review established that most of the contact with Mr A was with one nurse, who visited but required little if any input or commitment from Mr A himself.

[7] The 2014 SEN Code of practice now refers to the issuing of Education, Health and Care Plans and not "statements" of special educational needs.

6.6.2 Again there have been substantial changes in this service since the period under review. Mental health services in Norfolk are reported to be more alert to child safeguarding issues, with a “Think Family” approach clearly embedded in policy and guidance. Standards of staff supervision, including safeguarding supervision, have been improved. Awareness has been raised with the establishment of a dedicated safeguarding team. Safeguarding forms part of the mandatory training for staff at all levels. This account was echoed by CSC with social work staff reporting that their links with adult mental health services were much better and that adult services were making more referrals to CSC. Mr A was never seen as a high risk case, in terms of his mental health, but services are also reported to have developed a greater alertness to the effects on a family of a chronic mental health condition.

6.6.3 However, at the relevant time this was clearly an important missed opportunity and links between mental health services and children’s services can sometimes be weak. Consequently there is a recommendation from this report.

6.7 Escalation of concerns

6.7.1 At no point did agencies seek to escalate their concerns to more senior staff when they did not receive a satisfactory response from CSC. The Headteacher from School 6 did talk to a line manager but did not pursue the matter when this was not productive. She reported that her personal awareness had been raised by this case and that she would take a different approach now, not hesitating to contact senior officers when she thought that necessary.

6.7.2 Nonetheless this issue is again frequently identified in SCRs and there is a recommendation from this review.

6.8 Serious Case Review process

6.8.1 This has been an unusual review. It considers “historical” events that have been superceded by the detailed review of more recent events in Southampton. It has been conducted without the usual structure of staff interviews, management reviews and so on.

6.8.2 That has generally been appropriate but the review still required a good deal of administrative and managerial input, progress chasing and liaison across a range of agencies. In evaluating the conduct of the review the Board Manager and the Lead Reviewer both judged that it would have been helpful to have maintained a more structured process. This would have enabled a clearer overview of the progress of the review.

7. RECOMMENDATIONS TO THE NORFOLK SAFEGUARDING CHILDREN BOARD

7.1 Introduction

7.1.1 These recommendations to the Board reflect the key lessons to be learned from this review. The review does not make a recommendation for every point of learning that has been identified.

7.2 Recommendations

7.2.1 The LSCB should require the local authority to demonstrate that, where a child may be at risk of significant harm, investigations and consequent assessments are conducted without delay and meet all procedural and good practice requirements. These will include

- being consistently directed and managed by an appropriate senior officer
- seeing the child(ren) involved and treating them as individuals
- consulting with those who have parental responsibility
- making thorough agency checks
- drawing on specialist advice when necessary
- providing formal feedback to those who have made referrals
- ensuring that key decisions, including a decision to take no further action, are “countersigned” by an appropriate manager
- ensuring a timely approach to all aspects of assessment and decision-making

7.2.2 The Board should audit multi-agency involvement in child protection investigation work to ensure that all agencies are appropriately involved in decision-making and follow-up. Audits must include involvement in Strategy Meetings / Discussions and in agreeing action following medical examination and identification of possible non-accidental injury.

7.2.3 The Board should engage partner agencies in establishing a core standard for supervision in respect of the safeguarding of children, and should satisfy itself, by way of regular audits, that this is used routinely and effectively.

7.2.4 The Board should require all agencies to promote the use of escalation procedures when there is disagreement between professionals, and should audit the use and effectiveness of these arrangements.

7.2.5 The Board should review and strengthen as necessary arrangements for recognising and responding to children who may be affected by domestic abuse.

7.2.6 The Board should disseminate the findings from this review so as to raise the profile of the particular safeguarding needs of children from travelling communities.

7.2.7 The Board should require the Norfolk and Suffolk NHS Foundation Trust to demonstrate that staff are equipped to respond appropriately to child safeguarding issues in their work.

7.2.8 The Board should require Norfolk County Council (Education services) to confirm that there are satisfactory arrangements for notifying the relevant local authority when children with Education, Health and Care Plans move out of Norfolk.

APPENDIX A THE LEAD REVIEWER

Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 45 SCRs in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile SCR reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX B TERMS OF REFERENCE

Serious Case Review: Family O

1. Introduction

1.1 Family O, a family of seven children, lived in Norfolk between 2004 and 2011. They subsequently moved to Southampton where, in 2013, it came to light that all the children of the family had been seriously abused over many years. The Southampton Local Safeguarding Children Board (SLSCB) carried out a Serious Case Review (SCR) which was published in May 2014.

1.2 Having considered that SCR and liaised with agencies in Southampton, the Chair of the Norfolk Safeguarding Children Board (NSCB) decided on 12/5/14 that a SCR should now be carried out to consider the involvement of local agencies when the family lived in Norfolk.

2. The Context of this Review

2.1 In determining these terms of reference the NSCB has been mindful that:

- It is more than three years since these children lived in Norfolk: the nature and shape of services has changed significantly since that time, and some sources of information will no longer be available or relevant.
- The SCR in Southampton has already considered in detail a number of cross-cutting issues, particularly the significance of race and culture in this case.

3. The Process of this Review

3.1 In view of this context the Board has decided to adopt the following approach.

3.2 The SCR process will be led by an SCR Panel. The Panel will be led by Kevin Harrington who wrote the Southampton SCR in this case, and will also write the Overview Report from this review.

3.3 Each of the agencies identified as having some knowledge of or involvement with the family during the time that they lived in Norfolk has been asked to review their records of any contact with the family between 2004 and 2011, and to draw together a chronology of any contact **which may have been significant**. Agencies are asked not to detail every contact.

3.4 The SCR Panel will consider the chronologies drawn up by the agencies and will confirm the key issues arising from that information. The Panel will determine the best way to ensure that those issues are analysed and understood, so as to feed into an Overview Report. This may involve a range of methods including individual management reviews from agencies and direct interviews with key individuals or groups.

APPENDIX C REFERENCES

This Overview Report has been generally informed by the publications detailed below. The Overview Report from the earlier review, conducted by the Safeguarding Board in Southampton, also refers to a number of publications which informed the consideration of issues relating to the safeguarding of children from travelling families (and the issue of elective home education which is less relevant here).

- Working Together to Safeguard Children,(HM Government 2013)
- The Victoria Climbie Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- London Safeguarding Children Board – SCR Toolkit (2010)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)