Norfolk Safeguarding Children Board

Independent Overview Report

Child M

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1. Introduction

Purpose

1.1 Working Together 2013 is clear that 'professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, 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' (Working Together, March 2013, Chapter 4 Para 1).

1.2 Serious Case Reviews (SCRs) and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

2. About the Author

2.1 I, Glenys Johnston, am the author of this Overview Report. I am an Independent Social Work Consultant with extensive experience in compiling Overview Reports for Serious Case Reviews and of chairing LSCBs; I have had no previous involvement in any aspect of the case.

3. Terms of reference

Background

3.1 Case M involves the sexual abuse of a child by her siblings, over a significant period of time. This case has been reviewed before, after it was referred to Norfolk's Safeguarding Children (NSCB) Serious Case Review Group (SCRG) in May 2011. At this point it was agreed that although the criteria for an SCR were met, the Board would exercise its discretion and undertake a MAR instead, as it was felt this was the most appropriate method to identify any learning.

3.2 The MAR began in September 2011 but did not conclude until March 2013. There were a number of reasons for this delay including changes of staff. In March 2013 the report was taken to the NSCB in an exceptional meeting to look at learning from both this case and a similar one that had been agreed the previous year.

3.3 The case was re-referred to the SCRG in March 2014. The referral was related to a further incident of sexual abuse to Child M, involving another brother, Child F.

The scope of the Serious Case Review

3.4 At the SCR scoping meeting held on 3rd April 2014, it was agreed that the scope of the SCR would start where the MAR concluded, i.e. October 2011, but reference would be made to the previous MAR report, where appropriate. The review would cover the period that ended in February 2014. It was also agreed that this review would include information on all the children in the family, not just the victim.

Terms of reference

3.5 The review has followed two parallel lines of enquiry.

1. The practice in relation to this case, i.e. what happened to the children and how effective agencies were in protecting them from harm and the extent to which the abuse could have been predicted and/or prevented.

3.6 In addressing this, specific questions have been addressed by IMR authors and the Overview Author:

- How good was the quality of assessments, decision-making and evaluation of risk for all four children in the family? Did the risk assessments include risks posed by the abusers outside of the family?
- Was there consistency and continuity of involvement of all relevant partners in the management of the case and to what extent was it multi-agency? Did one agency's views hold sway over the others?
- What was the nature of the plans put in place to protect the children and were they effective?
- What levels of support did the children receive? Were there resources available to manage harmful behaviour and address the impact that sibling on sibling abuse had on the family?
- To what extent were the children's views considered and contribute to management of the case?
- How well did the practitioners involved understand child sexual abuse and sexually harmful behaviour and how did this impact on their ability to assess parenting?
- How effective was supervision if understanding was weak and what support was put in place to escalate concerns?
- How did the Crown Prosecution Service (CPS) contribute to the case, in terms of the reasons for decisions made in respect of prosecution and other legal options? What was the impact of those decisions?
- How were recommendations from the previous review taken forward (or not) in the management and decision-making for this case?
- Could the abuse have been predicted and/or prevented?

2. The organisational response: why did protective arrangements not happen following the MAR? :

- The Board's process to implement the recommendations from SCRs and Multi-agency Reviews; and
- The processes that partners use to disseminate learning with their own agencies.

These issues have been addressed in a separate report.

4. Methodology

4.1 This Overview Report includes information in relation to all the family, with more limited information in relation to the eldest boy, due to his vulnerability.

4.2 Although most of the information within the scope of this review relates to the period agreed, significant events prior to the period have been included.

4.3 The review was commissioned by NSCB on March 2014 and notification was sent to the National Panel of Independent Experts as required.

4.4 The review was overseen by Russell Wate who is an Independent Consultant with no previous involvement in the case; he chaired the Serious Case Review Panel which was made up of senior managers from each agency/department that had been involved in the case.

4.5 CSC had some difficulties in providing a senior manager with a social work background to attend the Panel meetings, on reflection; this would have been helpful to provide professional challenge and oversight although no criticism of the individual is intended.

4.6 Each agency provided an Individual Management Report (IMR) written by a manager who had not been involved in the case. Their reports were considered at the Panel meetings which were regularly held; during these, the Panel explored and challenged the information provided by the IMRs and identified key learning and themes.

4.7 The details of Panel members and IMR authors is contained below:

AGENCY	**SCR Panel Member** **Title**	**IMR Author** **Title**
Children's Services Social Care	Gordon Boyd Assistant Director	Operational Manager
Children's Services Education	Education	Education Advisor
NHS Norfolk Community Health Care	Anna Morgan Director of Nursing, Quality & Operations, NCHC	Named Nurse, NCHC

AGENCY	SCR Panel Member Title	IMR Author Title
NHS Designated Team (reporting on GPs)	Cath Gorman Director of Quality & Safety Great Yarmouth & Waveney CCG	Designated Nurse, Safeguarding Team
Norfolk Constabulary	Detective Superintendent Julie Wvendth Head of Safeguarding and Crime Reduction	Detective Inspector
CAFCASS	Linda Nelmes Service Manager	Improvement Manager
Crown Prosecution Service	Anil Patani Assistant Chief Constable	Barrister
NPLaw	David Johnson Solicitor	Solicitor (summary report)
NSCB	Abigail McGarry NSCB Board Manager	N/A

4.8 A meeting of the practitioners involved in the case was held on the 11th September and the outcome of their discussions has been included in this report. The practitioners who attended the meeting are to be commended for their honest reflections and their commitment to learning lessons and improving practice.

5. The Involvement of the Family

5.1 Family members were invited to contribute to the review. I have met Mother, Step-father (the father of the youngest child, Child B) and the main subject of the review, Child M. The three brothers have not been interviewed, either because they declined or it was not felt to be appropriate. The views and experiences of those I met have provided the review with their perspective of the services they received and are appreciated; they have been included in this report.

6. Genogram (Family Tree)

6.1 A genogram is a type of family tree which contains additional information about the family composition. It presents key information about the family in diagrammatic form and can include social data such as births and deaths, age and sex of family members. The genogram is attached as Appendix 1.

6.2 The family members are White British, their first language is English and there is no evidence that they practice a religion. The children all have a different father and are therefore half-siblings.

7. Summary of Facts

The period prior to October 2011, the start of the period covered by this review

7.1 The family was known to a number of universal and specialist services throughout their lives; this was not a family which was "below the radar of services" for example:

- Child M's mother had been known to a General Practice since she was a child. From 1996 she consulted her General Practitioner (GP) on a number of occasions for support with her anxiety and depression.
- Children's Social Care (CSC) were involved with the family from soon after the birth of the first child, Child H due to concerns about him possibly being a 'shaken baby' there were also concerns about neglect , the boys' developmental delay and their 'extreme' behaviour. Records also indicate concerns about physical abuse.
- It is clear that the GP practice was well aware of the history of the sexual abuse of Child M by her eldest brother Child H and they supported her mother, when she presented at the surgery with stress and anxiety connected to the incidents.
- The children visited the GP practice with various minor illnesses and Child M's youngest sibling Child B was referred by the GP for an ADHD assessment which did not lead to a diagnosis of ADHD, although his behaviour subsequently improved when he took medication that is commonly prescribed to treat the condition.
- The first allegation of sexual abuse by both Child H and Child F against Child M was made in January 2008. Both Child H and Child F were immediately removed from home. The allegation against Child F was subsequently withdrawn and Mother immediately took him home, Child H admitted the offence but also soon returned home. To reduce the risk of further incidents, CSC relied on a written agreement with the Mother and Step-father (Child B's father) around the supervision of the children; they did not feel a Child Protection Conference, to agree a multi-agency child protection plan, was necessary.
- In November 2008 Child M made a second allegation of sexual abuse by Child H. Following this disclosure Child H was initially placed with his Step-father's parents and was later accommodated by Norfolk County Council.
- An Initial Child Protection Conference (ICPC) was held in January 2009 to consider the second disclosure. The children were not made subject to a child protection plan but Child F, Child M and Child B were made the subjects of child in need plans. Specialist support was identified for Child M but it is of note that due to waiting lists it was some months before this began. As Child H was in the care of the local authority, his care and safeguarding arrangements were included in a 'Looked After Child' Plan.
- The child protection plan was reviewed in March 2009 and it was agreed that individual work with Child H would be carried out by Norfolk Youth Offending Team (NYOT). It was believed that as he was not living at home he presented as a 'low risk 'to his sister, however, it was also agreed that any plan to return him home would be robust and the Police would be kept fully

informed of this change. Child F's school agreed to undertake 'keep safe' work with him, with the proviso that should any issues arise then CSC and NYOT would consider whether a further risk assessment was needed.

- During 2009 it is clear that the plan for Child H was focussed on returning him to his family. The MAR appropriately raised concern about the lack of a robust assessment of risk around this plan. Evidence that this plan was in any of the children's interest is at best contradictory e.g.:
- Mother being seen as a strong protective factor despite:
    - Child H's relationship with Mother being problematic because of her emotional fragility and preoccupation with her own needs.
    - Mother appearing to be unable to accept Child H's level of responsibility for the abuse of his sister.
- Similar contradictions are noted with regard to the Step-father in that although he was thought to be supportive he is reported to have said "Child M is as much to blame as her brother" and he attended only one of the sessions at The G Family centre that supports parents and children.

7.2 By the end of October 2009, Child H had returned home having spent increasing amounts of time there. The MAR was clearly critical of the lack of a child protection plan around this significant event and the CSC chronology evidences very little discussion with partner agencies or a thorough risk assessment and plans for all four children.

7.3 In November 2009 there was an incident of domestic abuse by Step-father; he was charged by the Police and left the family home.

7.4 Over the following months, Mother and Step-father intermittently separated and reunited. In July 2010 Child F was assaulted by Step-father when he attempted to force Child F to go back into the house. When arrested, Step-father reported to the Police that some time before this event he had seen Child F "pulling Child M's shorts down". The Police and CSC conducted an assessment interview with Child M which did not confirm the allegation.

7.5 CSC decided to end Child M's sessions at The G Centre in July 2010 because: Step-father had left the family home; Mother was filing for divorce; the Police clarification interview with Child M regarding her allegation against Child H was inconclusive and she had withdrawn her previous allegations against Child H.

7.6 In early October 2009 the family were threatened with homelessness. Mother and the four children spent a number of months sharing one room in a motel. There was later a significant concern raised that, during this time, Mother shared a bed with Child B whilst Child M slept in a bed with her older brothers.

7.7 In early 2011 there were a number of incidents of harassment by Step-father but there is very little record of involvement by CSC to indicate that the impact of this was assessed and in early May 2011 there consideration was given to closing the case.

7.8 On 10th May 2011 Mother contacted the Police to report a third disclosure of sexual abuse of Child M by Child H. Child H was immediately removed from family and again became 'looked after' by the Council; he was placed in bed and breakfast (B&B) accommodation, despite his own vulnerabilities, age and risk to the landlord's children. CSC records of September 2011 state that Child H had admitted to abusing Child M and, despite concerns expressed by the Police and the

Social Worker's intention to move him to more appropriate accommodation he was, at that point, still living in the B&B accommodation.

7.9 Following this third allegation an ICPC was held in July 2011, the children became subject to child protection plans (CP Plan) under the categories of emotional and sexual abuse. Concerns were expressed about Mother's ability to keep her children safe. Later the same month the case transferred to a new Social Worker (SW2) in the Safeguarding Team in CSC.

7.10 In September 2011 the records of the Review Child Protection Conference appear to indicate some limited positive progress however, all the children remained subject to child protection plan.

7.11 The MAR dated September 2012, but not accepted by the NSCB until March 2013, examined the above events up until October 2011. At this point there was clearly a significant, worrying and complex social care history in relation to the life experiences of all four children. Concerns included significant trauma in relation to:

- Repeated allegations of sexual abuse, sibling on sibling and a query about possible 'other' unidentified abuser/s;
- domestic abuse;
- physical abuse;
- neglect-characterised by a chaotic and hostile home environment;
- children with special needs; and
- concerns regarding Mother's mental health /depression.

Significant events during the period covered by the review October 2011- February 2014

Summary of events in 2011

7.12 In October 2011, at a core group meeting, progress on delivering the child protection plan was reviewed. A number of outstanding i.e. delayed actions were identified including:

- Legal advice remained outstanding.
- The parenting assessment remained outstanding, despite the high level of concerns regarding Mother's awareness and understanding of risk.
- Home Based Care needed to be chased up to help Mother with boundary setting, safe supervision and routines.
- Insufficiently frequent visits by CSC.
- The need for direct work with the children.
- Outstanding Police interviews and investigation.
- Outstanding issues regarding an assessment for ADHD and medication for Child F.

7.13 From the beginning of November there was regular input from the Home Based Care worker provided by CSC. The records of this involvement give a number of examples of the difficult behaviour sometimes displayed by Child B and Child F and Mother struggling to control this.

7.14 At the end of December 2011 there was a case discussion which appeared to relate to the MAR but was recorded as a "SCR" discussion. The SCR chronology states, "Social worker does not believe that Child F is a significant risk of sexually abusing siblings. Police have investigated and have interviewed Child F but there is no further information. Children's Services are not aware of where the investigation is at. This is unhelpful as we cannot proceed with a risk assessment."

7.15 The delay in therapeutic work was also recorded and so was Mother's inability to acknowledge her responsibilities. Additional outstanding work included the completion of a chronology, a risk assessment and core assessments on the three youngest children.

7.16 As has been previously mentioned, Child H was permanently removed from the family home after the third allegation of sexual abuse in 2011. He was placed in B&B accommodation and remained there until mid 2012. It is clear that his needs and vulnerability were not sufficiently addressed in this placement and there were concerns about Child H being able to access appropriate therapeutic intervention both to address his level of risk and his own needs as the victim of childhood abuse. His mother ceased contact with him and he was not allowed to see his siblings.

7.17 As the CSC IMR states "Child H's experience represented a significant dilemma as professionals struggled with finding a suitable resource to provide therapy. He was seen as a victim as well as an offender but because he was not prosecuted he could not access Youth Justice resources. Therefore Child H went without the necessary therapeutic support which might have prevented his repeated offending and could have saved Child M from the impact of further abuse".

Summary of events in 2012

7.18 During 2012, Mother's mental health appeared to improve. She reported to the GP that the circumstances at home were settling down and both she and the children were only seen with minor ailments.

7.19 At the beginning of January 2012, the Police informed CSC that the investigation regarding Child H was inconclusive and there would be no further actions by them. They also informed the Social Worker (SW3) that Child M had reported that Child F had touched her and Child H had shown him what to do, this added to the previous concern raised by Step-father that he had seen Child F touching Child M. Records indicated CSC attempted to gain further clarity from the Police, without success, but there appeared to be no concerns expressed by Child M or picked up by adults during on-going sessions with CSC workers and the family, which appeared relatively positive.

7.20 At the end of February 2012, Mother had a telephone consultation with the GP to discuss Child M's abdominal pain from which she had suffered over the previous few weeks. Although they were offered three different appointments that afternoon, Child M was not seen but Mother later told the GP that she was attending an outpatient appointment with the paediatrician the following morning, it is not known whether this appointment took place.

7.21 From the spring of 2012 there was noticeable and regular input from the CSC manager/supervisor who identified improvements in the functioning of the family but also the need to continue to work within a child protection plan and ensure agencies provide services.

7.22 On 18th April 2012 Mother reported to the GP that they were undergoing family therapy at provided by Child and Adolescent Mental Health (CAMHS).

7.23 In June 2012, sessions began with Y (a service for children and young people with learning disabilities who are experiencing mental health difficulties and/or behaviour difficulties. Within a very few sessions the therapist raised concerns about the family dynamics; she was

particularly worried in relation to Mother's capacity to support the children. She requested a professionals' meeting but as SW3 was away from work this was postponed and created a long delay.

7.24 There was another review of the child protection plan at the end of September 2012. The children remain the subject of child protection plans but the category was changed to emotional abuse, the category of sexual abuse being removed. It was also agreed that the requested professionals' meeting would be held before the next core-group meeting. The professional's meeting was held on the 16th October and agreed there was a need for a psychological assessment of Mother to explore her attachments to the children, her emotional availability to them and to address the impact of this on her ability to care for them. There was also an agreement that the SW3 would complete Core Assessments.

7.25 Records from Home Based Care Team during this period noted frequent comments about the displays of aggression by the boys and Mother's inability to cope with this. Alongside are other observations of a more positive nature about the children appearing happy, doing better at school and general improvements within the home.

7.26 By the end of October 2012, the therapist from Y suggested to Mother that she would find some sessions with a psychologist helpful to look at her own past and how this affected her and that this could help professionals to support her better. This message was strengthened by CSC who addressed with Mother their on-going professional concerns about her ability to protect and to meet the children's needs.

7.27 At this time Child B's father was pursuing contact through the court process.

7.28 In early December the Home Based Care worker attempted to raise with Mother her observations of a recent visit when Child F's behaviour had been particularly aggressive, disruptive and quite spiteful. Child B had become 'wound up' by this and in turn started to kick Child M. The worker intervened but Child M had responded that this was "OK as it lets Child B get it out of his system". Child M had been determined to persist with this approach because she felt that she was "helping". The worker wanted to discuss the inappropriateness of Child M being in a parenting role. Mother's response was that she had been reassured by a paediatrician that her own parenting was not in question; it was outside influences that contributed to the family's situation

Summary of events in 2013

7.29 During 2013 the children continued to see their GP with minor ailments and Mother continued to be seen with depression and anxiety. Early in the year Child M attended the GP surgery with a minor condition. At this consultation the GP checked that she had no contact with her older brother Child H, who was known to the GP to be the sexual offender.

7.30 In January 2013 a core assessment was completed by CSC.

7.31 The psychological assessment of Mother and Step-father's private law application for contact with Child B were proceeding through court. CSC were directed by the court to disclose information and files and prepare a chronology. The CSC Adolescent Support Team began working with Child H who was no longer living in B&B, but living in more suitable accommodation.

7.32 The Social Worker visited the family on the 13th February and recorded no issues of concern.

7.33 On the 15th February Mother contacted the Police to report that Child F has sexually abused Child M.

7.34 Following Mother's call to the Police, Child F was arrested and the Police and the Emergency Duty Team (EDT) Social Worker (SW4) carried out a strategy discussion to plan the investigation following which SW4 noted her concern that Mother may be unable to offer Child M any emotional support, because she was overwhelmed by her own emotional needs.

7.35 In March 2013 CSC discussed the case with their legal advisors to consider seeking agreement from the court to remove Child M and Child B. The legal advice was to share and implement the recommendations of Psychologist TS, initiate proceedings but seek no order until further assessments of Mother's capacity to parent were identified and undertaken.

7.36 At the strategy meeting held on April 10th 2013, all previous actions had been addressed, these included that:

- a RCPC had been held;
- risk assessments of Child F by EN School had been undertaken;
- the Social Worker had completed risk assessments regarding the safety of Child M and Child B remaining at home; and
- Care Proceedings were to be commenced.

7.37 Further issues discussed at this meeting included:

- the need for a specialist forensic assessment to determine the risks;
- whether it was in anyone's interests to prosecute Child F, as he too was a victim;
- historic concerns and new disclosures from Child F;
- Mother's complex needs and previous behaviours including telling Child M and Child B not to tell CSC of the circumstances at home as they would be "taken away"; and
- although Step-father had previously been investigated by the Police this was about physical and not sexual abuse.

7.38 At a core group meeting in April 2013 concerns by a number of professionals were noted in relation to Child M's emotional state and her physical appearance. As a result of this EN School wrote to the Social Worker suggesting it might be useful to bring on board more "psychological models "and expertise.

7.39 Mother was referred to mental health services in April.

7.40 In early May, the CSC team manager (JK) informed the Police Child Abuse Investigation Unit (CAIU) that CSC had prepared paperwork for Care Proceedings and had requested NPLAW to commence Care Proceedings. It was envisaged that a forensic assessment would be conducted if there was an agreement from all parties. On 31st May he wrote to NPLAW requesting an update as to why there was a delay.

7.41 Records of the 20th May 2013 indicate that Child F had disclosed to another young person in his care home that he had sexually abused his sister and this had put him at considerable risk. Child F was subsequently moved to EN School until a suitable placement could be identified. Mother indicated she would like to see Child F and weekly contact began shortly afterwards at Child F's school. This contact was not maintained and by mid–August Mother said that she had not disengaged with Child F but that she had "backed off" because her visits were having a negative and distressing affect on him. She criticized the decision to consider allowing Child

F some contact with his father and brother. In September, the Police reached a decision to take no further action in relation to the criminal case against Child F. The application for a Care Order in respect of Child F was separate from that of his siblings as Mother did not oppose this and it was granted in November 2013.

7.42 During May 2013 a new Social Worker (SW5) was appointed. He was concerned about Mother's parenting which he observed during his first visit to the home, in particular her lack of control and emotional insight into Child M. Over the next few months, these observations were increasingly supported by similar comments from the Home Based Care worker. Evidence from the records suggest that Mother reacted badly to the Social Worker's attempts to address his concerns and this was shown in a number of different ways; she made negative remarks to other workers in front of the children and inappropriately shared her adult views with Child M.

7.43 Further work was being completed around this time, including 'wishes and feelings' work with Child B and a parenting assessment of Mother by a specialist organisation (CL).

7.44 Care proceedings were initiated in June 2013.

7.45 In September, the Social Worker and Team Manager discussed the parenting assessment which concluded that Mother would need considerable support to meet the long-term needs of the children.

7.46 In October Child M offered some perceptions of her life, in discussions with a student social worker. She spoke of being upset when Child F was charged with rape but felt she could not show this in front of her mother in case it upset her. Child M thought her mother was a good mother but that she handled things differently from other people, who had not been through as much. She wondered if mother would make it through the day if she was put in care. In another session she asked the student social worker about sexual issues as wanted to know more about them.

7.47 Observations of Child B throughout this period identified the previous themes of aggressive outbursts which Mother appeared unable to contain and a sense of his "ruling the roost" at home. In discussions he reported being bullied at school and that nothing was done about it. He expressed concern for his mother – particularly her financial situation because she had less each week since Child F had been removed. Child B said he loved his mother but worried about her. He also said she made him happy when he was sad. He stated he did not wish to see his father because he had frequently seen him hurt his mother. Child B also stated that his father smacked him and made him hurt Child F and his mother. He expressed a wish to see his older brothers, Child H and Child F.

7.48 In November, professionals reported increasing concerns about Child B, Child M and Mother all of whom were displaying different signs of anxiety and upset. Child B's behaviour in particular was causing concern as was Mother's apparent inability to deal with it. Professionals picked up signs that Mother was blaming Child B for his behaviour and attempting to put pressure on him to behave nicely when they were around.

7.49 During car journeys to an advice and support project ZP, Child M raised aspects of her life with the Student Social Worker (SSW1) who travelled with her. These included issues around friendships at school, whether she would be staying with her mother and whether she could keep her safe. Child M was not sure that her mother could keep her safe all of the time. Child

M said that she would like contact with her own father but had not discussed this with her mother because it would make her angry and upset. (When I met Child M she also told me this). It is of note that between one journey and the next Child M had raised this issue with her mother. She later reported her mother had been angry but had then calmed down. Child M stated she would not be discussing it again. Child M also used the opportunities in the car to have a conversation about personal relationships.

7.50 In November 2013, Child M was seen at the GP surgery with Mother; the GP reassured her that Child M was well. The GP was aware of Child M's history and asked Mother to wait outside so that he could talk to Child M alone. He reported that she was quiet and uncommunicative but indicated nothing that led him to ask further questions.

7.51 During December, records indicate that the relationship between Mother and CSC was deteriorating still further. Mother was clearly not in agreement with the care plans, she rejected the concerns raised by SW5 and she felt confident that the Guardian was supporting her view although the Guardian had been careful not share her views at an inappropriate stage. The Home Base Care worker felt that there was little point in her sessions as Mother was not taking advice and guidance as she felt that the problems were not of her making.

Summary of events in 2014

7.52 In early January 2014, SW5 noted a more positive change in Mother. Mother said that attendance at the Freedom programme and other confidence groups had helped. She also acknowledged that she and the children needed ongoing therapy. In my meeting with Mother she said she resented the length of time it had taken to put her in touch with the Freedom programme and other courses.

7.53 In January 2014 Child M was taken to her session at ZP. She was described as "very talkative" and took the opportunity to raise a number of issues. She was clearly concerned about the possibility of being removed from home. She wanted to know about the court case and how decisions would be made about the future for her and Child B. Her worker explained that with so many different views there was likely to be another court hearing. Child M asked that the worker be honest with her. The worker responded by saying that in her view her mother had not always managed to keep her safe and may have spoken to her and Child B about inappropriate things however, she knew her mother loved her very much and would fight for them. This appeared to please Child M. After her session, Child M requested further sessions during which she asked lots of questions about sex. In my meeting with Child M she said that she knew her mother wanted to protect her and keep her and Child B safe.

7.54 On the same day, Child B was also concerned and worried that he may be taken away from home; he thought this might happen because Child M did not like him and this had happened to his other two brothers. SW5 felt it was inappropriate to discuss details of the abuse with Child B and that he should be told only that Child H and Child F had hurt Child M very badly.

7.55 It is clear within the court proceedings that CSC and the Guardian had opposing views. The Guardian believed the children should remain with Mother and would not support their removal, CSC were of the opinion that the children should be removed for their own safety and care. The Team Manager and Operations Manager reviewed the key documents in the case, the Final Statement, the Core Assessments, the CL report and the Guardian's Report and confirmed their view that the children should be removed but also agreed the need for a contingency support plan in case the court decided the children were to remain with their mother.

7.56 Professionals around the children, in the lead up to the court case were aware of the anxieties of the children and took steps to reduce this as much as they could but it remained a very stressful time for Child M and Child B.

7.57 On the 12th February, Judge X stated that he felt that it was correct that there had been a contested hearing and commended the assessment and input of the Social Worker (SW5). He said he had however, been impressed by the evidence given by the children's mother and had given due weight to the views of the children who had said they wished to remain with her and he agreed with this. He decided that the removal of the children would not be in their interests and directed CSC to compile a plan of support within the community, he also ordered a 12 month Supervision Order and intensive support.

7.58 Following the court case a package of intensive work for the family was commissioned using an independent social worker. When I met the Independent Social Worker she commented how beneficial Mother had said she had found her involvement, for example she was now able to allow her children more freedom such as allowing Child B to walk to school. She also said that there had been different advice from Social Workers as to whether Mother had to obtain CRB clearance before allowing the children to go away or stay with friends and this had been stressful. Mother told me that the help from the Independent Social Worker had been invaluable and she was disappointed that when it ended, there would be a gap of almost three months before a CSC support worker would be able to begin.

7.59 At this point CSC transferred responsibility for the case to a different Senior Social Worker (SS1) individual work with Dr O also commenced; this meant that a new set of workers started again with the family. At a Review Child Protection Conference on the 5th March 2014 the children were removed from their child protection plan as they were now subject to a Supervision Order.

7.60 During 2014 there was still evidence that Child F's needs were not being fully addressed. Professionals raised concerns that delays by the Police, in deciding whether to prosecute Child F, had left them worried about being unable to provide the therapeutic intervention he needed. He had been subject to appropriate reviews as a 'looked after child' and this had overseen his care however, despite the high levels of supervision provided by the care home, Child F he had been able to leave the residential unit at night and had involved himself in anti-social behaviour, this was subsequently addressed in the care planning process.

8. Analysis of involvement

8.1 This section considers the key questions agreed in the terms of reference and evaluates the quality of practice both single and inter-agency.

- *How good was the quality of assessments, decision-making and evaluation of risk for all four children in the family? Did the risk assessments include risks posed by the abusers outside of the family?*

8.2 Overall the quality of assessments varied, some were good but some were insufficiently rigorous. There were several assessments of the family but none of them considered every member as an individual and there appears to be almost nothing explored about Mother's own history of childhood or her experience of being parented. Little appears known about the

impact of all four fathers or of others who had contact with the children and may have posed a risk to them.

8.3 In the course of their work, which commenced in September 2012, Y assessed the parenting capacity of Mother and appropriately raised concerns about her ability to change and provide emotional warmth for the children, due to her concerns about herself. This was also identified by SW 5 in September 2013, when he completed a parenting assessment which focussed on Mother's parenting style.

8.4 In carrying out her work, the Guardian assessed the needs of the children and reached the view that they should remain at home with their mother, a different but equally well evidenced point of view was reached by SW5.

8.5 There was insufficient consideration of the impact of domestic abuse given our understanding of the links between domestic abuse and sexually inappropriate behaviour.

8.6 There was scant consideration of the risks posed by people outside the family, despite reference to them in documents. This issue was also not addressed by the IMR authors, which is indicative of the lack of seriousness attached to the potential harm none family members may have presented.

- *Was there consistency and continuity of involvement of all relevant partners in the management of the case and to what extent was it multi-agency? Did one agency's views hold sway over the others?*

8.7 The involvement of the GP was consistent throughout the lives of the children and he clearly understood the situation within the family. It is therefore disappointing that given this wealth of information, his participation within the child protection process was minimal, with him attending only one child protection conference in September 2011 and not providing further conferences with reports. Hearing and participation in the discussion at the conference would have provided him with a greater understanding of the dynamics within the family and of Mother's ability to protect Child M.

8.8 However, the GP was aware that there was a community paediatrician involved and therefore felt that the medical/health aspects were well presented.

8.9 From October 2011 onwards, all three children are reported as having very good attendance at school which enabled staff to have an oversight of their appearance, mood and behaviour.

8.10 Education staff were well aware of the family difficulties and contributed effectively to their safeguarding. The Parent Support Adviser from Child M and Child B's previous school (AD Primary) was able to make contact with NQ Primary and attended the first meeting at the school. It provided a very good level of continuity of information between the schools that would not have been possible through written records alone.

8.11 NQ Primary School and RU High School also worked very closely together in the summer term of 2011, to ensure a comprehensive transition programme to support both Child M and Mother for Child M's move to a secondary school in the autumn. The staff at both schools felt that this was very successful. All of the staff involved were fully aware of the circumstances surrounding the family, so felt that they could focus on Child M's needs. However, although reports submitted for core group meetings by RU High School presented a very positive picture

of Child M's behaviour and progress during her time with them, notes in the records taken during transfer meetings between RU High School and VW Academy in September 2013, indicate that opinions and concerns around Mother had perhaps not been fully presented at these meetings.

8.12 All of the educational professionals interviewed as part of this review felt that the core group meetings played a very important and useful role. Being able to hear the involvement and view point of other professionals from different agencies was very beneficial and provided them with a fuller understanding of what was going on outside of school. However, one teacher raised the issue of being unable to contact other professionals from the core group in between meetings. As a teacher in a single school, she was relatively easy to contact, but found that it was almost impossible to get hold of other professionals. At one point, telephone numbers had been changed without any notification which made this more difficult.

8.13 There were a number of staff changes and periods of absence during the involvement of CSC in this case and this had a detrimental effect on the understanding of the history of the family and at times the relationships between social workers and other professionals. As the Ofsted Inspection of Child Protection stated in 2013 "Whilst some positive examples were seen of well-formed relationships between social workers and children; for example in relation to supporting private fostering arrangements, other children experience too many changes of social worker. This is in part systemic, as different teams are allocated different parts of the child protection process and implementation of the transfer protocol is variable. However, it has also been a consequence of a turnover in social work staff. Frequent changes of social worker hinder continuity and engagement, and prevent the formation of positive relationships with children, their families and carers".

8.14 The change of Social Workers had an impact on the frequency of their visits which deteriorated at times; the consistency of information sharing between them and other professionals and decision making was also affected. In the Education IMR frustration is expressed about the lack of consistent social work support. Their view is that although social work support increased later, the legacy of the earlier lack of effective and consistent social work and multi-agency work had a negative impact for a long time.

8.15 Until almost the end of the period covered by this review, there was good consistency and continuity from the School Nurse, and the Designated Professional for Child Protection in school. Communication between these practitioners was good however, when the School Nurse was absent from November 2013, she was not replaced. The importance of ensuring consistent support in such circumstances is addressed by a recommendation in the Health IMR.

8.16 The involvement of others was either more sporadic, or as in the case of NCH&C teams, dependent on their ongoing work with the family. For example, the Y team ceased attendance at meetings once all of their work was concluded and their recommendations had been reported to the core group or conference. The paediatricians attended some but not all core groups and conferences. Best practice would be for discussion within the Health, prior to meetings, to enable the most appropriate attendance. This did occur at some stages, but was not as well coordinated at others.

8.17 In the view of the School Nurse, professionals worked well together until the disclosure of Child F's abuse of Child M, when professional relationships became more strained.

8.18 It is evident that NCH&C professionals have acted positively and they were pro-active in advocating for the children. Paediatricians highlighted their anxieties about the children at senior CSC management level, professionals meetings, strategy discussions, core groups, case conferences and as part of this review. The School Nurse made special arrangements for joint and further supervision, while the Family Therapy Team called for a professionals meeting.

8.19 Those health professionals interviewed by the Health IMR author thought that CSC was the major decision maker, and only their views held sway. For example when the School Nurse reported that Child M had said she was unsure of Child F because of his aggression, this was explained by CSC as an 'historic' rather than an ongoing problem, although it had been recently made in the presence of two health workers at a joint assessment. As a result, health professionals lacked confidence in the plans made to address the needs of the children, they felt their views were not listened to and they had to continue to advocate for the children and influence decisions.

8.20 There was some good practice by the Police including responding promptly when offences were reported and some good oversight by Police supervisors. However, there were a number of issues where practice could have been better and these are covered in the Police IMR. In summary, they include ensuring there is more informed supervision and oversight of decisions, the importance of using specialist or appropriately trained officers and reducing as far as possible frequent changes of staff, so that the risks and issues are consistently understood. Recommendations and actions to address all of these are contained in the IMR.

8.21 The records evidence a level of frustration between CSC and the Police, the former trying to obtain information about the decision by the Police to bring charges against Child F (to assist them in their plan to provide him with therapeutic support) and the latter expressing their frustration at the lack of information being disclosed by CSC.

8.22 It is clear that the introduction of the Multi-Agency Safeguarding Hub in September 2011, which brought together key professionals from Police, Health, Advocacy, Probation and Children's Services has led to an improvement in initial information sharing and decision making. It must also be recognised that existing Police procedures have also been improved over recent months especially around the areas of supervisor reviews and risk assessments. A Disclosure Protocol was agreed in May 2014 to ensure information between the Police and CSC and their legal representatives is promptly shared to enable decisions to be made about appropriate legal processes.

8.23 There was good liaison between the Guardian and the Social Worker and evidence that each informed the other of their thinking and views; to that extent there was multi-agency management. However, it was apparent that, on occasion, some decisions were made without reference to the Guardian, for example Child M's referral to the MAP. This concerned the Guardian for three reasons:

- The expert from CL had not at that point completed her assessment and advised on the appropriate nature of therapeutic intervention for Child M and her family.
- In her view, the person assigned by MAP to work with Child M was not appropriately qualified to undertake the work with her.
- The MAP worker had not been adequately briefed about Mother's family history of sexual abuse, the care proceedings or the appointment of an expert.

8.24 The Guardian and CSC did not agree about the appointment of an expert (the local authority initially supported this but subsequently changed their view and wished to discharge the

appointment) or the desired outcome of the Care Order applications for Child M and Child B however, neither view influenced the other. The views were, therefore, quite properly tested in court and the court found in both instances that the views of the Guardian and the children should be accepted.

8.25 The court was clearly concerned about the lack of progress by the council in delivering the agreed actions i.e. the referral for an assessment of Mother and children by CL. In October 2013 the District Judge asked that his concerns about what he described as the 'abject failure' of the local authority, in putting into place what the court ordered, be recorded. He was also concerned that a report from Y had not been provided promptly when he was considering the future arrangements for Child F.

8.26 At the end of their involvement in the legal proceedings, NPLAW reflected on their practice and CSC's management of the case. They identified different practice by CSC in providing them with clear instructions; the practice of March 2012 was assessed as good with full, complete and unambiguous instructions being provided. However, they identified less sound practice in respect of the instructions regarding the disclosure of documents from the Police during which full, complete and unambiguous instructions had not been obtained from CSC and the instructions were inadequate.

8.27 During the course of this review, and in my discussions with professionals as part of the review of the implementation of the MAR recommendations, I have heard that for several years some agencies were of the opinion that CSC dominated decision making and found it difficult to accept professional challenge which led to some professionals feeling it was pointless to do so. The Multi-agency Child Protection Procedures set out the importance of raising concerns where professionals do not agree:

"Working with children and families can be difficult and complex. Safeguarding and child protection involves dealing with uncertainties and making important, complex decisions on the basis of incomplete information to demanding timelines in changing, often hostile and stressful circumstances. The repercussions of leaving a child in a dangerous home or splitting up a family can be extremely damaging. However, these judgments and decisions have to be made and it is essential that the professionals do so in a considered way, constantly guarding against the tendency to cling to original beliefs, searching only for information that supports those beliefs and devaluing or reframing new information that counters them.

Whilst the multi-agency nature of the work can bring benefits in terms of differing perspectives and experience, there may also be times when professionals disagree with decisions taken or actions planned. Resolution of those differences is an integral part of professional co-operation and joint working to safeguarding children but can become dysfunctional if not resolved in a constructive and timely fashion. The end result may be less favourable outcomes for children. The aim of this policy is to describe a way of resolving professional disagreement, ensuring that the child or young person's safety and welfare is the paramount consideration".

However, there is no evidence that the NSCB Resolving Professional Disagreement Policy was ever followed, other than the convening of a professional's meeting whose purpose was not explicitly to resolve difficulties.

- *What was the nature of the plans put in place to protect the children and were they effective?*

Overall, there were significant weaknesses in protecting the children through appropriate child protection plans; these were not based on sound risk assessments or comprehensive multi-agency arrangements. There were significant delays in implementing the plans that were made and some were overly dependent on an over-optimistic view of Mother's ability and willingness to comply with them.

- *What levels of support did the children receive? Were there resources available to manage harmful behaviour and address the impact that sibling on sibling abuse had on the family?*

8.28 Although there was no lack of involvement with the family and good support from some agencies such as school and Health, there were significant delays in providing specific help to the children in addressing abusive behaviour and the impact of that behaviour on Child M. The Ofsted Inspection of Child Protection Arrangements 2013 highlighted this issue of delay stating that, "Children and young people are not consistently in receipt of timely specialist services to meet their assessed needs"

8.29 Delay was an issue in a number of key areas for the children and is set out well in the CSC IMR viz:

- It (delay) was evident from the time of the Initial Child Protection Conference (ICPC) in 2011 and may have played a role in workers' perceptions of risk, believing it to be more historic than current.
- Delay in the core assessment of Jan 2013 .This assessment should have been recommended at the ICPC in 2011 and completed shortly thereafter. It can only be a matter of speculation as to what may have been the benefits of a thorough child-centred assessment at the beginning of the child protection planning process but is highly likely to have been positive.
- The delay in making a prompt decision about whether to prosecute Child F's for abusing Child M was raised in several meetings and was believed to have a negative effect on Child F's well-being.
- The decision that the children remain with their mother brought about another delay in relation to therapeutic input for Child M and Child B as there was a need for Mother to have intensive input first, in order to ensure she could support her children and provide a safe environment for them before their therapy could begin safely.
- The issue of communication was clearly a concern at the point of transfer between the Children In Need team and the Safeguarding team within CSC. There were lost files and an absence of a robust transfer. This impacted on the delivery of service and the understanding of significant historical and current concerns. It also contributed to the delays.
- The professionals involved with the children since mid 2011 appear to have communicated well together at multi-agency meetings at one level but this does not appear to have been effective in addressing delay in a number of areas .

8.30 Overall CSC gave insufficient support to these vulnerable children, despite the damaging experiences they had suffered. Workers as a group were overly reassured by minor improvements in the home situation compared to a long history of poor parenting by Mother. The result was that the status quo continued until another event of sexual abuse occurred, which might have been prevented had clear focus on the seriousness of the issues been maintained, and correspondingly rigorous analysis and intervention provided.

8.31 In my meeting with Mother she expressed her anger at the lack of support over the last four years and describes this period as having been "*lost to her children*". She said she had derived

considerable benefit from attendance at the Freedom programme and other courses and groups and her confidence and understanding has increased but this could have been achieved at an earlier stage.

8.32 Child M and Child B who live with their mother have no contact with their fathers. Child M appears happy and is a gentle young person of considerable compassion. She is receiving counselling which is sensitive to her needs and her wish to take things slowly. Child B's behaviour has become a little more manageable with the support of the Independent Social Worker

8.33 Child H and Child F no longer have contact with their Mother, their fathers or their siblings and are therefore young adults without family support. Their turbulent childhoods; their lack of positive parenting and the lack of therapeutic support at the right time has created two very vulnerable young men, this does not bode well for their future.

8.34 In summary, the children have not received the support they needed at the time they needed it.

- *To what extent were the children's views considered and contribute to management of the case?*

8.35 The IMRs contain extensive information about the engagement of agencies with the children, particularly Child M and Child B. It is clear that professionals observed, monitored and listened to the children and that professionals were sensitive to their current and changing circumstances.

8.36 Child M in particular was given many opportunities to talk and express her views although this is less evident from the records in relation to Child H, Child F and Child B.

8.37 SW5 and the Guardian were of differing views as to whether Child M and Child B should remain in the care of their mother. Both sets of opinion were valid and well considered. In the care proceedings the Judge made no criticism of their differing views but he placed great weight on the expressed views of the children, which were that they wanted to remain at home.

- *How well did the practitioners involved understand child sexual abuse and sexually harmful behaviour and how did this impact on their ability to assess parenting?*

8.38 It would appear that the level of understanding of child protection and sexual abuse was acceptable but the knowledge of sibling sexual abuse was variable. It is a complex and challenging area of work, involving children as perpetrators and victims and requires considerable skill to manage and address all aspects. When this is combined with neglect and emotional abuse the challenge is increased.

8.39 The Youth Offending service had specialist knowledge of inter sibling abuse but this was not accessed by Child F or practitioners involved in managing his case because he was not prosecuted, this was regrettable and could have been addressed.

8.40 The CL and Y had good understanding of child sexual abuse but their views differed, the former being of the view that if Mother was provided with support she may be able to care for the children effectively, Y felt this was unlikely given her difficulties in putting their needs first,

8.41 The focus of the work changed in September 2012 when the category of abuse that the children were registered under changed from emotional and sexual abuse to a single category of emotional abuse, this implied that sexual abuse was no longer a significant concern and the work lost focus.

- *How effective was supervision if understanding was weak and what support was put in place to escalate concerns?*

8.42 Overall the frequency and quality of supervision and involvement of senior managers is reported positively in the IMRs however, given the failings in this case I have to question how effective this was.

8.43 In CSC it was well and consistently evidenced from the end of September 2011 when a new Team Manager was appointed. There is no evidence to indicate that he or any other professional missed current signs of sexual abuse or that they failed to act upon new information. However, historical information was not regularly considered within the context of a changing picture.

8.44 From the spring of 2012 there was noticeable and regular input from the CSC manager/supervisor who identified the improvements that had been made but was also clear regarding the need to continue to work within a CP plan and ensure agencies provided services.

8.45 The Police IMR highlighted improvements to be made to supervisory practice in terms of allocating child sexual abuse cases to appropriately trained and experienced officer and ensuring ABE interviews are carried out by similarly appropriate people. This does not however indicate failings that would have had a significant bearing on this case.

8.46 The Health IMR provides no comment about the supervision arrangements for the GP but makes clear that the GP, who most often saw the family, had considerable experience in child protection.

8.47 There was good evidence of supportive supervision for NCH&C staff, including support at the professionals meeting of 2012 by the deputy Named Nurse, who had been part of the MAR in 2011.

8.48 Supervision for paediatricians was limited to consultation with peers and an enhanced provision might have helped clarify concerns and coordinate the escalation process.

8.49 The two Education Senior Designated Professionals (SDPs) were both new to their roles when they first became involved with the case. Although both had received SDP training and they carried out their work to the best of their ability, they felt that their new roles presented them with very steep learning curves and at times they were unsure of the processes involved with the case. When interviewed for this review they expressed concern at the lack of supervision for themselves and support in managing the impact of the work on them.

8.50 The Guardian had a good level of knowledge and understanding about sexual abuse and had access to an experienced supervisor.

- *How did the Crown Prosecution Service contribute to the case, in terms of the reasons for decisions made in respect of prosecution and other legal options? What was the impact of those decisions?*

8.51 The work of the CPS was both sound and sensitive. In July 2013 the CPS became involved following the Police investigation into the allegation of rape by Child F on Child M which was made in February 2013. The Police expressed their concerns that their interview with Child M had lacked specific questions and this might have an impact on the evidence. The CPS considered this information and whether it had been considered of sufficient weight for prosecution, they came to the view that a jury would not convict Child F on the basis of what evidence had been gathered and there was a need for further investigation.

8.52 The CPS also considered what Child M had said when she was interviewed by the Police in relation to her previous complaint against Child H; it appears that the Police mistakenly informed the CPS that Child H had been prosecuted whereas this was not the case. This error was later corrected and although unfortunate it did not have a bearing upon the decisions made by the CPS in relation to Child F.

8.53 The CPS were concerned about the lack of CSC records and asked the Police to obtain all relevant information and to conduct a second interview with Child M, during which she appeared to change her answers. The CPS thought this may have been as the result of her being told that if she continued in her allegation she may be taken away from home. In pursuing this issue the Police were again asked to request information from CSC who appeared reluctant to provide it. These inter-agency difficulties created a significant failing as provision of the information at an early stage would have assisted the CPS in coming to a view.

8.54 Given the lack of information and evidence, the CPS advised the Police that no further action should be taken against Child F as to have prosecuted him could have had serious consequences for both him and Child M.

- *How were recommendations from the previous review taken forward (or not) in the management and decision-making for this case?*

8.55 These issues are addressed in a separate review but in summary the recommendations were not applied to the on-going management of this case.

- *Could the abuse have been predicted and/or prevented?*

8.56 Given the previous history i.e. prior to October 2011 at which point this review started, there was sufficient evidence to indicate that the risks to Child M remained and were largely unaddressed. Few services had been put in place to address the abusive behaviour and the risk management plan within the family was inadequate. There had been almost no assessment of Mother's capacity to protect the children.

8.57 Regrettably it is my view that the there was sufficient evidence to suggest that further abuse was a possibility and it could have been prevented.

9. Themes

9.1 During the course of this review several themes emerged which are summarised here for completeness although most are covered in answering the above key questions.

Escalation and professional challenge

9.2 Different professional opinions are not uncommon in child protection work, based as they are on professionals having contact with different members of the family, different professional perspectives, knowledge and experience.

9.3 Family members may relate differently to individual professionals in different situations. For example a child can behave differently in school to the way they behave at home or in a clinical setting.

9.4 In this case there were a number of different perspectives, Y raised serious concerns about Mother's ability to change her approach to parenting, CL felt Mother could change with additional support and the Guardian felt that Child M and Child B should remain at home, though the Social Worker did not.

9.5 The important issue is that these differences should have been explored openly and resolved and they appear not to have been.

9.6 There is also the issue of challenging parents in a constructive manner. Some social workers felt that Mother resented being challenged and would disengage or make complaints about the worker; this avoidant behaviour was not addressed appropriately. Child protection plans can make an important contribution to practice, they should be written so that what is expected of professionals and parents/carers is explicit and can be monitored.

9.7 Escalation has been covered above, it is a critical part of internal, single agency practice and multi-agency practice and should not be seen as an aggressive act, it enables practice to be reviewed and drift and delay (amongst other issues can be addressed). Concerns in this case were not escalated appropriately; although the reasons for this are not known it is possible to speculate that this may have been because of a view that they would not be positively received by CSC.

Disguised compliance

9.8 Some families can find the involvement of professionals extremely positive and helpful, but some find it difficult as it can require changes in their behaviour, with which they may not agree or be unwilling to address.

9.9 Professionals should always be alert to the possibility that families will appear to be compliant with plans but in fact may not be. They can use a range of behaviours to disguise their lack of compliance, some can be quite overt or hostile such as by not attending meetings or complaining about staff but others can be more subtle. These can include drawing the focus of attention onto themselves; telling their children to behave in a positive way in front of professionals and not telling them of what is happening at home; identifying themselves with professionals and behaving as a quasi professional or reporting that they have learned a great deal from attending courses or being involved in therapeutic work when in fact they have not internalised the learning. These were all features in this case but were rarely challenged. For

example good progress by Mother was identified at the RCPC in March 2012 however, this positive view was overly reliant upon mother's compliance over the previous few months and did not address the core entrenched nature of the real issues of concern; it was almost as if professionals felt that with the departure of Child H all risks had been removed.

9.10 Professionals should always be alert to the possibility that parents/carers will appear to be in agreement with what needs to happen but may not be. There is also the possibility that parents can play professionals off against each other, unless there is close multi-agency working and clear joint plans. Periodically, multi-agency meetings should reflect on the number of agencies involved in a family and the appropriateness of this, as it can lead to families feeling overwhelmed with a range of demands and expectations.

9.11 The views of the children, in assessing whether changes are being made, are crucial to reach a conclusion about compliance or lack of it by their parents/carers.

Appropriate professional experience

9.12 Professionals gain experience through training, supervision and practice. In cases of sibling on sibling abuse very careful consideration should be given to the allocation of work, that is not to say that it cannot be undertaken by professionals with limited experience but if it is it must be supported by skilful supervision, co-working, access to specialist advice and monitoring.

9.13 This did not always happen in the case; this implies no criticism of the individual workers who did their best but it indicates a lack of appropriate consideration by line managers.

Holistic assessments

9.14 Professionals are constantly "assessing" families throughout their work. This helps to form their opinions and the way they work. Formal written assessments are a critical factor in planning for children; in this case there was no holistic assessment of the family. Whilst a core assessment was undertaken it did not look at each child as an individual, or at the family as a whole, together with an assessment of who else might be visiting the home and in contact with the children. There is no evidence that Mother's own history and experience of being parented was fully assessed. It is notable that she appeared to have little contact with her own family but the reasons for this was not explored.

Start again culture

9.15 Staff changes and organisation re-structuring can have a significant impact on child protection work, sometimes for the better. However, it always leads to a lack of continuity with time needed to develop new relationships, build trust and understand the situation.

9.16 It is not possible for organisations to completely manage staff changes but in complex cases of high risk such as this, measures to minimise the impact should be put in place. The new worker needs to have access to good records, (in this case some were missing) and to read them. Chronologies provide a very useful tool for reflecting on the history of a case and what has been tried before. The transfer of work should be undertaken carefully with time spent between the previous and new worker and their supervisors to discuss the case and arrange the hand-over and introductions to the family of the new worker.

9.17 In this case this thorough approach was missing in CSC and some Social Workers 'began again' with a new approach which at times created a different focus and delay; the change of child protection categorisation which removed that of sexual abuse also had a significant impact as it reduced the focus of this being an on-going risk. There were also some delays in the schools' understanding of the children's circumstances when they changed schools as records do not appear to have been shared on some occasions.

Learning from reviews

9.18 Much has been written nationally about the number of reviews that do not actually lead to changes in practice. The issue of the application of the learning from the MAR in this case is the subject of a separate report, but the lack of this was a significant factor in the period that followed that covered by the MAR.

10. Learning from Practitioners

10.1 At the practitioner's event which was held as part of this review three key questions were considered and the views of those who attended are summarised below:

1. **What were the key issues in this case in relation to resolving professional disagreement and how could safeguarding meetings (such as child protection conferences) be made more effective?**

10.2 Practitioners felt that it had been difficult to challenge each other when the parents were present. They felt that if this is likely to be a difficulty there should be a discussion as to whether disagreements will take place during the meeting or addressed separately. They felt that workers need to be appropriately trained, confident in their practice and well supervised and if they express a concern their view should be taken seriously and addressed, regardless of their professional status or seniority.

10.3 They felt that the minutes of child protection conferences should accurately reflect the actions that were agreed in the meeting and that any delays in implementing them should be addressed promptly.

2. **What were the issues in relation to securing more holistic assessments, to prevent a 'start again' approach?**

10.4 Practitioners felt that chronologies of significant issues are vital to reflect on what has happened before; that improving the transfer of case files is important; that sharing significant and appropriate information is still a problem in Norfolk; that changes of workers has had a detrimental impact on the overview and management of the case and that people with appropriate skills in interpreting the behaviours of children is essential and would have been useful.

3. **What were the issues in relation to deceptive compliance by Mother?**

10.5 Practitioners identified some barriers to addressing this difficulty, this included the failure to agree a joint approach to challenging and monitoring Mother at a separate multi-agency professionals meeting and they questioned whether in complex cases such as this, specialist clinical supervision should be available.

11. Conclusion

11.1 This was a very complex and challenging case for all professionals. It involved a mother, four different fathers and four children, three of whom had special needs and behavioural difficulties.

11.2 There were significant features and events which added to these complexities, domestic abuse, neglect, emotional abuse, physical abuse and sexual abuse by two of the siblings of their sister.

11.3 Some professionals found Mother difficult to work with, they felt she did not always share their concerns and she did not like being challenged. They found it difficult to engage her in effective, safe plans and to assess what was really happening. From my meeting with Mother it is clear that she also found her relationship with several professionals difficult. She felt that some professionals were helpful but some were overly intrusive and lacked understanding. She found their level of scrutiny added considerably to her stress and the plan to remove the youngest two children exacerbated her levels of anxiety, it also undoubtedly created considerable stress for the children concerned. She remains angry that there were delays in providing her and the children with appropriate support.

11.4 There was organisational change in Children's Social Care and staff absences in Health which had an impact on the consistent involvement of some staff, notably Social Workers who were deployed from different teams over time.

11.5 Professionals took their responsibilities seriously and were clearly concerned about the children. There is good evidence of the two youngest children being listened to. However, despite some good inter-agency engagement and communication there were differing professional views and some inter-agency frustration which was not escalated and resolved in a way which served the children well.

11.6 There was drift and delay in some aspects of the case management which delayed a full understanding of Mother's parenting capacity, willingness to understand the concerns of professionals and her ability to change her behaviour. These delays meant that support to the children was not provided at a time that best met their needs. It has had an impact on them, their relationships and their lives which has left them vulnerable and may be long-standing.

11.7 The prevailing culture, which developed over time, of CSC being seen as an organisation that was unwilling to listen to partner agencies and the lack of specialist knowledge or advice in relation to abuse by siblings also contributed to the abuse continuing. Despite the commitment and best efforts of some social workers the lack of rigorous and effective management oversight failed to fully address risks at the appropriate time.

11.8 This SCR covers the events of the last three years, the practice of the previous period in terms of professional understanding and agreed plans had an impact on this later period. It is regrettable that the learning from the Multi-Agency Review of 2012/13 was not applied to the on-going management of the case.

12. Recommendations

12.1 Individual agencies have identified a number of recommendations and the implementation of these will be monitored by the Norfolk Safeguarding Children Board.

12.2 In addition the following recommendations are suggested for the Board to address.
The Norfolk Safeguarding Children Board should:

a. Ensure that all agencies remind staff of the importance of appropriate challenge and escalation and monitor the use of the Resolving Professional Differences Policy.
b. Address, locally and via NHS England, the issue of GP engagement and or attendance at Child Protection Conferences and relevant multi-agency meetings to increase their contribution and understanding.
c. Monitor practice in relation to the transfer of cases from one professional or team to another so that it can be assured that this is safely managed and all information, including significant issues from the past, is passed on to avoid a "start again" approach.
d. Consider the comments made by professionals i.e.:
    i. The difficulties of professional challenge when parents are present and the need to consider a separate professionals' meeting.
    ii. The value of chronologies when transferring cases and the need to recognise the potential impact of changes of workers.
    iii. The need for professionals involved in cases to have the appropriate skills to communicate with children with difficulties or have access to professionals who do.
    iv. The need to have access to specialist advice in complex cases such as like this one.

    and agree how these will be addressed.

e. Include in single and multi-agency training the issues of:
    i. Professional challenge
    ii. The features of disguised compliance and how to recognise and address this
    iii. The importance of including the past experiences of both parents in assessments
    iv. The importance of regular reflection and of re-evaluating professional opinion in the light of new information.
f. Ensure that all agencies review the provision of child sexual abuse training, including sibling abuse, the links between domestic violence and sexually inappropriate behaviours and address any shortfall.
g. Monitor the appropriate use of the Disclosure Protocol.
h. Ensure that Serious Case Reviews and other multi-agency reviews are completed within timescales, that an appropriate senior manager from all the agencies involved in the case being reviewed are able to attend meetings that oversee the review, that emerging recommendations are implemented as they arise and the learning from reviews, whether published or not, is disseminated promptly.
i. Given that this is the second review of this family and the potential for the abuse to occur again, the NSCB should assure itself that the current arrangements for all the children are reviewed and demonstrably provide effective support, safeguarding and protection.

Report Ends

Appendix 1 – Genogram