Norfolk Safeguarding Children Board

Learning from Serious Case Reviews

Case U

Serious Case Review: Case U

This presentation sets out:

- Summary of the case
- Methodology
- Terms of Reference: key research questions
- Findings and recommendations
- The Board's response

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Serious Case Review: Case U
Summary of the case: the Family

- Family of 8 children. Four youngest subject to this SCR: all four sexually abused by their father (stepfather to oldest of the four, Sibling 1)

- Sibling 2, first to disclose after being placed in Foster Care by the Local Authority

- Father subsequently received a life sentence with a minimum tariff of 16 years for a number of sexual offences.

- Mother pleaded guilty to an offence of child maltreatment and was sentenced to 2 years imprisonment.

- An older Sibling also pleaded guilty to a sexual offence with a child and received a 2-year Suspended Sentence with a Supervision Order.

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Serious Case Review: Case U
Summary of the case: why an SCR?

- The children were seriously harmed as a result of prolonged sexual abuse. There were concerns about how organisations or professionals worked together to safeguard them.

- Concerns over a number of years regarding: very poor school attendance; home conditions; problematic behaviour including aggressive behaviour by one of the children; children going missing and self-harm.

- Multi-agency involvement: children in receipt of services from Children's Services, schools and a variety of health professionals at the time of disclosure

- The children's conscious or unconscious communication not being understood

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Serious Case Review: Case U Methodology

Scope of review is between 2005, when agencies first became involved with family, and 2015 up to disclosure and the immediate response to the children.

Agencies involved were:

- Children's Services (NCC)
- Norfolk Constabulary
- Education Advisory Service
- Clinical Commissioning Group
- Community Health NHS Trust
- Acute Hospital NHS Trust
- Mental Health Foundation Trust
- District Council

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Serious Case Review:
Case U Methodology, cont.

Methodology used a systems approach in order to identify the deeper, underlying issues that may be influencing how services are provided to children.

The approach included:

- multi-agency collaboration on the SCR Panel,
- inclusion of front line practitioners:
  - 1-2-1 conversations with professionals involved in the case
  - Professional learning event
- meetings with family members
- a focus on systemic strengths and weaknesses.

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Case U: Historical information 2005 - 2011

Family composed of mother, father, four older siblings, and subjects of this SCR: Sibling 1: born 2001; Sibling 2: born 2004, Sibling 3: born 2006 and & Sibling 4: born 2007.

Father was treated for depression due to his own history of childhood abuse. Anger was a feature but he did not engage with mental health services.

Older siblings school aged with some concerns re behaviour

- Between 2005 and 2011: at least 7 referrals made to the Police and Children's Services regarding children going missing, home conditions, mental health issues
- Older Sibling (brother) identified by a psychologist in 2006 as suffering from anger, anxiety, PTSD and ADHD
- Allegations of inappropriate sexual behaviour by adults towards children/sexual abuse,
- Children using sexually explicit language and descriptions

Case U: 2005 – 2011, cont.

- 2006: concerning incident with Sibling 1, then aged 5, being forced to drink washing up liquid
- Father required by Children's Services to leave house temporarily in order to resolve his mental health problems and was assessed by a mental health practitioner.
- After 6 months father returned home with no further assessment by Children's Services.
- Separately, another police force sought and shared intelligence about the father '*regarding sexual abuse issues'* relating to his birth family with Norfolk Police.
- Parents separate 2007: father moves out but has continued involvement with parenting children

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Case U: 2005 – 2011, cont.

Health needs & diagnoses

- All of the children identified by the parents as having a range of underlying problems including ADHD and learning difficulties in Siblings 2 and 4
- Formal diagnoses by medical professionals were made after multi-disciplinary assessment.
- The mother had also experienced a serious health condition, and her health was considered to be an explanation of some of the difficulties.

Social care intervention in this period

- Occasional involvement of Children's Services prior to 2012, but not progressed beyond assessment.
- From 2011, long periods when the children were subject to a Common Assessment Framework (CAF): multi-agency approach taken when children have additional needs that do not meet threshold for Child Protection or Care Proceedings, i.e. statutory intervention. (CAF is consent based).

Case U: Recent past, 2012 – 2015 (disclosure)

2012: under CAF process

- Sibling 2's behaviour deteriorates, increasingly aggressive; mother and grandmother keen for her to receive further medication
- Sibling 4 identified as having significant learning difficulties as well as social, emotional and behavioural difficulties.
- Older brother referred to CAMHS for anger management. Later in the year, allegedly assaults female student at college. No further action taken by girl or her mother.
- Sibling 1, aged nearly 11, speaks explicitly about sex and rape by 14 year old, but later withdraws rape allegation. This led to an Initial Assessment, but assessment concluded case could continue to be managed under CAF

From this time onwards these behavioural and presentational difficulties, as well as school attendance, continued to be a problem for all the children

Case U: 2012 – 2015, cont.

- Mother admitted to hospital with serious health problems. Recorded that father and maternal grandmother were taking care of the children in her absence.

- Mother's health problems managed by GP and frequently referred to over this period, e.g. mother immobile, sleeping in hospital bed in front room

- Mixed picture of father's involvement.

- Sibling 1 starts self harming and talking about taking her own life; referred to CAMHS who conclude she doesn't have any mental illness

- Dec 2012: Sibling 1 goes missing and a second Initial Assessment is undertaken. Again, concluded that the case could continue to be managed under CAF as family was engaging.

Case U: 2012 – 2015, cont.

2013: Local District Council's Families Unit begin working with family.

- Primary role: to help family maintain tenancy
- Two allocated workers working with family for period of 11 months
- practitioners identified a wide range of needs and actions
- Included in CAF meetings
- Recorded Sibling 2's inappropriate sexualised behaviour and Siblings 3 & 4 as over familiar.

In early 2013 the mother was recorded by Children's Services as planning to '*trial alternate nights away from the family home for respite*' with other family members working collaboratively to provide care.

- Unclear what Children's Services' involvement was at this time and how/if arrangement was assessed

Case U: 2012 – 2015, cont.

Third Initial Assessment undertaken following a missing episode:

- Renewed court action regarding Sibling 1's school attendance
- Mother's physical health and the impact on the children
- The emotional health of both parents
- Mother going away to visit her boyfriend, leaving children with father who was said to 'struggle to cope'
- Conditions in the home;
- Quality of parenting and lack of progress or improvements.
- Sibling 2 suffering from bedwetting
- Neighbour reporting screaming and shouting – explained by mother as Sibling 2 having a tantrum.
- Sibling 4 withdrawn, very emotional and 'often looks very sad.'

Family Units worker also concerned about risks of Child Sexual Exploitation (CSE) in relation to Sibling 1

Case U: 2012 – 2015, cont.

After some delay, children put on a Children in Need (CIN) plan following third Initial Assessment in July 2013

Police called to house 6 times in Aug 2013 in response to violence witnessed by father towards Sibling 2 and Sibling 2's physical attacks on mother and grandmother

First CIN meeting held Oct 2013: focus on neglect of Sibling 1, shifting to Sibling 2's refusal to go to school Referrals made to:

- Children's Services Targeted Support Team (support resource)
- Children's Services Home Based Support (support resource)
- Starfish, the children's Learning Disabilities service run by NCHC

Nov 2013: Families Unit withdraw services

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Case U: 2012 – 2015, cont.

Father continues to be involved with family – seen as a supportive parent against the backdrop of neglect in the family home

December 2013: plan to take Siblings 1 & 2 into care if no improvements in family home. *Unsustainable improvements noted over a period of 18 months, leading to Sibling 2's eventual placement in foster care and subsequent disclosure*

January 2014: Social Worker visiting weekly. Concerns noted by support workers (homebase support & targeted support) included

- Parenting capacity work undertaken with the mother not having lasting impact
- Sibling 1 speaking to strangers on Facebook/mother's lack of concern
- Suicide notes written by Sibling 1 a couple of years previously
- Sibling 2 making penis shapes out of PlayDoh

Case U: 2012 – 2015, cont.

Core Assessment initiated in Nov 2013, completed in Apr 2014. It recommended that:

- Sibling 1 be placed in therapeutic foster care & referred for counselling and/or psychological assessment.
- Sibling 2's psychological assessment be completed
- Siblings 2, 3 & 4 to be provided with time limited assessments in foster care.
- Children to have regular contact with their parents and family.
- Consideration to family therapy on reunification.
- Mother and father to receive support in relation to their future parenting.
- Sibling 1's birth father to be assessed as a carer for her.

Nov 2014: Sibling 1 takes up her place in boarding school.

Case U: 2012 – 2015, cont.

Dec 2014: Sibling 3 told the safeguarding lead at her school that she had *'one big worry'* but she did not want to talk about it and that sharing it would mean she would get hurt.

Jan 2015: Sibling 1 refuses to return to boarding school. Police called to house and she told them she was worried about her mother's health and ability to cope and showed scars from self harming. Officer referred to Children's Services.

Mar 2015: Sibling 1 was placed in Foster Care with her mother's agreement, under S20 of the Children Act. Sibling 2 remained in the family home for a further 6 months

Case U: 2012 – 2015, cont.

Apr 2015: Family Court hearing orders:

- Psychological assessment of the family as a whole
- An educational assessment for Sibling 2
- Sibling 1 to remain with her foster carers
- Viability assessment of any identified family members.

Jul 2015: Core Assessment completed, informed by Educational Psychologist's and Clinical Psychologist's reports

Aug 2015: Children's Services Admission to Care Panel confirm foster placement for Sibling 2 would be made available

End Sep 2015: Sibling 2 accommodated in foster care placement,

Discloses within days of being placed

Case U: Oct 2015 – post disclosure

On day of disclosure some disagreement between Social Care and Police re the approach to be taken with family

- Police position: children should be subject to immediate police protection
- Social Care manager position: wanted planned interviews and any removal of Siblings 3 & 4 to take place at school the following day

Foster placements for Siblings 3 and 4 were accelerated during the day and the children were taken into police protection at 7.30 that evening

Over the following weeks and months all 4 siblings made a number of disclosures of sexual abuse leading to father's convictions

Case U: what the children said

Views on services provided sought from maternal grandmother, mother, Siblings 1 & 2.

We asked the them **what would help children in your position?**

"safety… and nice adults." (Sibling 2)

We asked them about **the number of people trying to help the family.**

"My attitude was 'Don't come into my house telling me what to do.'…. It would have been better if less people had been involved. If I didn't listen to my own mum, why would I listen to a load of people I don't know?" (Sibling 2)

NB Sibling 2 is no longer on any medication for any of the conditions that she was diagnosed with, although sometimes she still struggles to sleep

Case U Terms of Reference: Research Questions

Four research questions:

- What does this review tell us about the effectiveness of the multi-agency safeguarding partnership, particularly when working under thresholds of statutory social care intervention? This will include challenge around thresholds for intervention and fora for discussion and information sharing.

- How do professionals and agencies working with large families understand the needs of the individual children in the context of the whole family?

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Case U Terms of Reference: Research Questions, cont.

- How do we work with children so that they feel safe to talk about or otherwise express their feelings in order to enable professionals to make sense of what they are seeing and hearing?

- What does this case tell us about professionals' and agencies' level of confidence in identifying and working with different types of child abuse, including sexual abuse and neglect?

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Case U: Headline Learning from this SCR

- Understanding and mapping family history
- ‘Diagnoses’ masking what was happening and largely going unchallenged.
- The ‘noise’ in a family overwhelming professionals and agencies.
- Difficulty in recognizing or naming sexual abuse prior to ‘disclosure’.
- Crucial role of critical thinking and robust review.
- Implications of limited focus on relationship building, especially with adolescents.
- Drift – its impact and causes.
- The emotional context of children’s safeguarding

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Case U: Learning focus - disclosures

Indications throughout the story of each of these children that they were telling, but not being understood.

It is widely recognised that this is a common experience for many children "*the evidence….demonstrates that accessing help for child sexual abuse in the family environment, from both statutory and not-statutory services, is largely dependent on a disclosure"*.

Further evidence that the younger the child the more difficult it is for them to disclose.

Key challenge: to shift that burden of disclosure away from children and develop a safeguarding system which is not reliant on children speaking, but has the ability and confidence to take that burden from them. OCC (2015:34)

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Case U: Recommendation 1

The NSCB and its partners continue developing their multi-agency approach to Child Sexual Abuse so as to ensure it is not reliant on disclosure by victims, but on proactive and supported practitioners confident in their knowledge, skills and organisational support.

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Case U: Learning focus – critical thinking

Unless there is a fundamental focus by services on the emotional content and the impact on critical thinking for those working in safeguarding, children's needs in complex situations will continue to be misunderstood.

If safe practice is to be more consistently ensured, practitioners need to be provided with '"*an organisational culture in which they routinely receive opportunities to critically reflect on their experiences*". (Ferguson 2017)

Key challenge: developing an organisational culture which views its frontline staff as its greatest resource for which it will provide maximum support.

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Case U: Recommendation 2

The NSCB and Partner agencies review the support provided to front line staff in the light of the learning within this Review regarding the impact of the emotional content of child safeguarding on frontline professionals' capacity to maintain critical thinking in complex situations.

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Case U: Learning focus – adolescents

Lack of specialised services skilled in working with adolescents who may be experiencing abuse or neglect - alongside the difficulties that many other services appear to have in working effectively with this age group - is a nationally recognised problem

Sibling 1 did not build trusting relationships with the allocated workers from a range of agencies and this represented a significant gap in the support and help that could have been offered to her.

Key challenge: the needs of adolescents can only be met by a multi-agency approach.

Case U: Recommendation 3

The NSCB consider the effectiveness of services currently being commissioned, or otherwise provided, to adolescents who are at risk of abuse and neglect and identify how services can best be delivered to meet their needs.

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Case U: Learning focus – drift and delay Unintended consequence of strategic drivers

Case backdrop of intense workload pressures between 2013 and 2015. Children's Services Teams were dealing with:

- very high caseloads
- unallocated cases
- long working hours
- rapid staff turnover
- reliance on agency staff.

Impacted on Social Workers' capacity to build relationships or to regularly reflect and review the work.

Admission to Care Panels replaced by Locality Resource Panels in Oct 2017. April 2018 evaluation of this function in relation to children going into care shows that there is strong leadership and chairing arrangements of the panels, however a recommendation is that the roles and functions of other panel contributors can be made clearer to ensure their contribution adds value and is meaningful.

Case U: Learning focus – strategic drivers, cont

Strategic driver for Local Authority at the time: to reduce the numbers of Looked After Children

- Decision making Panels about placing children in care would frequently result in case workers being asked instead to try further interventions.
- The result, as in Case U, was not to build in constructive opportunities to create change in families, but to build in delay.

Situation widely recognised outside of Children's Services

Key challenge: understanding the impact that decision making in one agency can have on the wider safeguarding system and the need for an agreement amongst the multi-agency partnership as to how any risks can be mitigated against.

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Case U: Recommendation 4

The NSCB should explicitly develop a shared approach by which partners report on, or seek information about, any significant changes to an agency's function, resources or practice which could impact on multi-agency safeguarding, in order to enable peer response and where appropriate, challenge.

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Serious Case Review: Case U - The Board's Response

Recommendation 1: disclosures

- Learning from this SCR was disseminated ahead of publication with clear messages about not waiting for children to disclose
- Specialised Child Sexual Abuse (CSA) training in process of being commissioned to take account of learning from this and other SCRs
- The steering group responsible for implementing the CSA Strategy will continue to monitor and report on the impact of training and awareness raising on practice. Actions to date have included:
  - The development and promotion of a CSA awareness raising leaflet, in partnership with Norwich City Football Club
  - A comprehensive resource library on the NSCB website

Serious Case Review:
Case U - The Board's Response, cont

Recommendation 2: critical thinking

- Continued involvement with England Innovation Project, Phase 2 of Signs of Safety rollout, with focus on
  - Family network analysis and engagement
  - Quality of practice
  - Recording systems
- Joint supervision pilot commenced to support multi-agency network to think critically about 'stuck cases'
- Systemic Supervision: prioritised training for middle and senior managers within Children's Services

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Serious Case Review:
Case U - The Board's Response, cont.

Recommendation 3: adolescents

- NSFT (CAMHS provider) has provided information about a range of work it is involved in and recognised that there could be further improvements to their approach to working with adolescents.

- CAMHS Redesign ongoing in line with national developments around mental health services

- Children's emotional health and wellbeing a performance focus

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Serious Case Review:
Case U - The Board's Response, cont.

Recommendation 4: strategic drivers

Children's Services moved out of intervention January 2018. Ongoing improvements to services including:

- Smaller team sizes across frontline teams, smaller caseloads, increased management capacity.
- Team restructures so Family Intervention Teams encompass both Child in Need and Child Protection Cases, building in greater consistency for families and children
- Quarterly summaries are completed on all children open to a social worker to ensure easy to find updates/overviews on cases.
- County-wide implementation of a defined social work approach to intervention and training on CSA for social workers and team managers.

Serious Case Review:
Case U - The Board's Response, cont.

SECTION 11: AGENCY SELF ASSESSMENT

- S11 process developing beyond compliance checks
- Greater focus on agencies evidencing how they are disseminating and embedding learning from SCRs
- To include peer challenge and testing self assessment against working together in everyday practice

LOCAL SAFEGUARDING ARRANGEMENTS

- Under WT2018 (published 4 July 2018) , changes to way local safeguarding arrangements are governed
- Opportunity to review and develop Safeguarding Partnership Business Plan and Risk Register

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