Case Y
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Executive Summary
This SCR has analysed multi-agency services provided to a family of 6 children who were living together with their father (Mr. Y) in Norfolk. The critical period under review is between July 2015 and September 2016.

Why was this case the subject of a Serious Case Review?
In July 2016, three children in the family disclosed that they had been physically and sexually abused by their father. Mr. Y was later convicted of 11 offences and is currently serving a prison sentence. During this latter period of multi-agency involvement, concerns were raised about whether the children could have been safeguarded at an earlier point. These concerns were appropriately passed to Norfolk Serious Case Review Sub Group and a decision was taken that the circumstances in this case met the criteria for a SCR.

Involvement of multi-agency staff and family members
This investigation has examined key documents and spoken to staff and practitioners directly and indirectly through the involvement from each agency of experienced senior managers, who have had no direct involvement in this case. Local practitioners have been brought together to consider, discuss and comment on the findings of the review. The aim of this has been to gain an understanding of how the interaction between the various factors influenced the way practitioners responded to the children and their family.

Both parents were invited to share their perspectives about the services provided, Mrs. Y met with the lead reviewer, but Mr. Y declined. Three children in the family met with the lead reviewer and their perspectives are included in this report.

Key Recommendations
This SCR has identified areas of learning and development with the intention of strengthening the work of NSCB in safeguarding children from sexual abuse. Key recommendations include the following:

- Define and map a good practice model to support staff in safeguarding children from sexual abuse
- Strengthen work with perpetrators
- Evaluate implementation of NSCB CSA strategy across all agencies
1. Introduction

1.1 In July 2016, one of the children in the Y family, Sibling 4, disclosed to a member of teaching staff at his school that he and his siblings had been physically abused by his father and that his sister (Sibling 3) had been raped. Following police interviews with all six children, their father, Mr. Y, was arrested and charged with 11 offences, including nine rapes at the family home. On the same day, all the children were removed from their father’s care, and placed in foster care. At a subsequent criminal trial, Mr. Y pleaded guilty to all charges and was sentenced to life imprisonment. On the 12th September, Norfolk Serious Case Review Sub Group concluded this case met the criteria for undertaking a Serious Case Review.¹

The Aim of this Serious Case Review

1.2 In line with the requirements set out in Working Together (2015) this Serious Case Review aims to:

- Investigate and understand the services provided to the children and why things may have gone wrong as well as what may have gone well
- Identify any learning and resulting recommendations for action
- Invest in providing opportunities for practitioners to learn from their own and others’ experience, building confidence and empowering effective safeguarding practice for the future
- To provide a SCR report for publication

1.3 In response, Norfolk Safeguarding Children Board will:

Oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions².

¹ As specified in Working Together to Safeguard Children 2015.
² Working Together to Safeguard Children (DfE 2015)
2. **Methodology**

2.1 The methodology used for this Review is underpinned by the principles outlined in relevant statutory guidance,\(^3\) including the need to use a systems approach. In summary, central tenets of this approach are: multi-agency collaboration, inclusion of front line practitioners and family members and a focus on systemic strengths and weaknesses. The goal of the methodology is to move beyond the specifics of the case (what happened and why) to identify the deeper, underlying issues that may be influencing how services are provided to children. It is these generic patterns that count as lessons from a case, and changing them should contribute to improving practice more widely.

2.2 Data came from reviewing a range of multi-agency documents, compiling an integrated chronology, four meetings with a multi-agency Review Team, meetings with front line practitioners in 1-2-1 interviews and at a professional learning event, and meetings with family members.

2.3 In addition, the review was informed by existing learning from previous Norfolk Serious Case Reviews. The NSCB’s Thematic Learning Framework is included as Appendix 1.

3. **Process**

3.1 In line with this methodology, a Review Team was formed to undertake this SCR. This team of multi-agency senior managers had no direct line management of the case at the time; their primary responsibilities were to assist in providing relevant information, read and analyse documentation, participate in the interviews and in the Learning Event with staff (who provided services to the family) and contribute to the lessons learnt. The Review Team met on 4 occasions and included the following membership:

- Norfolk County Council Children’s Services

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\(^3\) Working Together to Safeguard Children (DfE2015).
The Independent Lead Reviewer

3.2 The Review was led and authored by an independent Lead Reviewer, Bridget Griffin. Bridget is a practiced Lead Reviewer/SCR author and is experienced in using a ‘systems methodology’; she is accredited by the Social Care Institute for Excellence (SCIE)⁴ and is independent of all the agencies involved.

Involvement of Practitioners

3.3 Interviews. A total of 14 interviews were held with multi-agency practitioners and managers, who provided services to the children under the time line under review.

3.4 Learning Event. A key feature of the methodology is a Learning Event, this event is attended by frontline practitioners and their line managers who were involved with the child and/or family members. It is a significant element of the review, as it provides a unique opportunity to hear the views of professionals who provided services to the children during the period under review. It is a key source of information for the Lead Reviewer and Review Team, and supports how lessons are learnt.

3.5 The Learning Event was well attended by multi-agency practitioners. The focus of the event was to examine the time under review, enabling a multi-agency perspective to be gained. This exercise brings out the story of multi-agency involvement, helping to identify key periods of time that were significant, and allowing the group to see how practice unfolded and how services were delivered from an

⁴ Learning Together SCIE: Munro, Bairstow & Fish. (2011)
inter-agency perspective. During the event, the key learning was discussed and explored, this allowed an understanding to emerge about what practice and service issues were relevant to how services were provided, and whether these issues are currently effecting service delivery more widely.

3.6 Summary feedback from the professionals following the learning event is included at Appendix 2.

**Documentation**

3.7 A multi-agency chronology, and a range of documentation, was provided to the Lead Reviewer and the Review Team to support information sharing and analysis, this included agency reports of service involvement and relevant documents from:

- Norfolk County Council Children’s Services
- Norfolk Constabulary
- Cambridgeshire Community Services NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Primary care
- School education records

4. **Involvement of the family**

4.1 It was felt important to involve as many family members as possible, to gain their perspectives and understand more about the services that were provided. The Review team were mindful of the number of professionals currently involved in the lives of the children, and decided not to speak to the two youngest children but the four oldest children were invited to meet the Lead Reviewer and the Board Manager. Sibling 2 decided not to be involved and her decision was respected and understood. The Lead Reviewer and the Board Manager met with Siblings 1, 3 and 4, and their perspectives are included throughout this report.
4.2 Mrs. Y willingly agreed to be involved in the SCR and met with the Lead Reviewer and the Board Manager.

4.3 Mrs. Y spoke about the number of times she told agencies over several years (including the police and children’s services) about the abuse the children were suffering, and the frustration she felt in not being believed. Mrs. Y spoke about Mr. Y’s violent and controlling behaviour and described how violent he could be, particularly after drinking alcohol. She spoke about her fear of him, and the fear felt by all the children. She said that “the children’s love for each other was used as weapon” to prevent them disclosing the abuse they were suffering.

4.4 Norfolk Safeguarding Board are grateful for the time given by Mrs. Y to this serious case review, her perspective is reflected in this report.

4.5 Siblings 1, 3 and 4 were advised during their meetings with the Lead Reviewer, that as part of the review process she would be attempting to meet with their father to understand how multi-agency practitioners could work together differently to better protect children from harm. The Lead Reviewer offered the children the opportunity to ask Mr. Y questions on their behalf.

4.6 Sibling 1 had no questions for his father. He said he did not think that his father was sorry for the abuse he had perpetrated.

4.7 For Sibling 3, she simply wanted to know: “Why he done what he did?”

4.8 Sibling 4 had three questions:

- “Why didn’t he look after us properly like a normal parent?”
- “Why didn’t he listen to people and get support?”
- “How did you feel when you did all this stuff to us?”

4.9 Despite several efforts to meet with Mr Y, he declined. It is disappointing that Siblings 2 and 3 cannot be given an answer to their questions, but it is important to acknowledge that there are no answers that could ever be sufficient to explain the abuse they and their siblings suffered.
5. **Terms of Reference**

5.1 During early discussions, the Case Y Review Team concluded that the scope of this review should include the history of multi-agency involvement from August 2012 (the date of the initial child protection conference in Norfolk) to July 2016 (when Sibling 4 disclosed the abuse). On receipt of the multi-agency chronology, the Review Team reviewed this scope at the Initial Review Team Meeting. It was concluded that the SCR would include what was known about the family history and the involvement of services, but that the detailed scope of the review should be as close as possible to the disclosure made by Sibling 4. This approach is in line with the statutory requirement to take a proportionate approach to SCRs, and allows for in depth learning to be drawn from the involvement of agencies that is most relevant to current safeguarding systems, processes and practice.

5.2 Thus, this review considers the history of agency involvement in the life of the children and reviews in depth a period of just over a year, from 1st July 2015 (12 months prior to disclosure) - 30th September 2016 (three months after disclosure to include service response).

**Key Lines of Enquiry**

5.3 The Review Team set 4 key lines of enquiry for consideration during this SCR:

- How effective are we at disseminating learning from previous SCR’s where sexual abuse was a dominant feature and what impact did this have on the way we managed this case?
- How well do we understand the behaviour of perpetrators and how does this understanding influence our work with children?
- How are we able to assess that on the balance of probability that a child is the victim of sexual abuse and how can we successfully safeguard a child when no formal disclosure has been made?
- What opportunities are available to multi-agency practitioners to consider possible prevailing mindsets and assumptions about families?
Family Composition

5.4 There are six children in this family, two girls and four boys, at the time of disclosure (and removal from home) their ages ranged from between 4 and 16 years, both parents were in their 30’s.


6.1 This section starts with a brief overview of the family circumstances, which were known to many but not all professionals, and provides a narrative summary of the professional involvement with the children in this family. The first section provides an overview of the historical context and the following section focuses on the time under review, appraising the practice response at different points across the timeframe and comments on why practice was as it was where this is known. Information has been anonymised as much as is possible, and dates removed to protect the privacy of the children and family members. This forms a foundation for the subsequent section which analyses the practice response as a whole and identifies the learning to be taken forward.

The children’s early experiences – a synopsis

6.2 During early childhood, Siblings 1, 2, 3 and 4 lived at home with their mother and father. Records show that the children lived in a household where violence was a significant feature of their early life. When Siblings 1, 2, 3 and 4 were all under 5 years of age, they were the subject of child protection plans for neglect. At the time, the family were resident in Coventry and there were significant concerns about the children’s emotional wellbeing due to the extent of the violence perpetrated by Mr. Y on their mother. Continuing concerns about their exposure to violence led to all four children being placed in the care of West Midlands Children’s Service and, after eighteen months, a successful parenting assessment resulted in the children returning to parental care in 2004.

6.3 From this time, until the family moved permanently to Norfolk in 2011, Mr. and Mrs. Y moved the family to various locations and were known to agencies in the West Midlands, Wales, London (Croydon) and Norfolk. It is not possible to fully
understand the extent of the family’s movements, as at various times the family lived in a caravan, but a review of the entries in the integrated chronology (detailing the input of various agencies) suggests that the family were highly transient over this period.

6.4 Records indicate that family life continued to feature domestic violence, and evidence suggests that the children were witness to the abuse of their mother. In October 2005, Mrs. Y was recorded in police records as fearing Mr. Y and of leaving the family home with the children. Five days later, her sisters (12 and 16 years) reported to the police they had been raped by Mr. Y. A criminal investigation took place however, the case did not proceed to court as the Crown Prosecution Service concluded there was insufficient evidence to achieve prosecution.

6.5 The following six years were characterised by Mrs. Y reporting assaults by Mr. Y, and by her moves in and out of the family home. It seems that during her periods of absence Siblings 1, 2, 3 and 4 were left in the care of their father. It appears that mother made several attempts to remove the children from the care of Mr. Y, and returned to live in the family on several occasions. Sibling 5 was born in 2009 and during 2012, when mother was living in Staffordshire, Sibling 6 was born. There were concerns about her ability to care for Sibling 6, and this led to Staffordshire Children Services advising her to place Sibling 6 in the care of father; this prompted mother’s return to the family home.

6.6 Mother’s return led to the active involvement of the police and children services in family life. Agencies were concerned that the six children would again be living in a household where ‘the history of prolific violence’ would continue to have a detrimental effect on the children’s wellbeing and there were additional concerns about a male relative of Mr. Y living with the family. These concerns led to a period of seven months when the children were made the subject of child protection plan under the category of emotional harm. Their names were removed from a child protection plan in March 2013 after their parents separated and the male relative left the household.
March 2013 – 1st July 2015

6.7 Between March 2013 and February 2014, the children were the subject of child in need plans and there was significant involvement from several multi-agency services. These included; social workers, police officers, several professionals at the children’s schools and within health services. During this time, it appeared that mother maintained some involvement within the family, by occasionally attending meetings regarding the children and taking them to medical appointments. The children were seen regularly by health professionals, all four children had been born prematurely: one child had some physical impairment and another was thought to be suffering from epilepsy. All the children received treatment for a range of childhood illnesses and minor injuries.

6.8 Of significance within this period, are the number of reports mother made to the police about the abuse of the children by Mr. Y. In September 2013, Mrs. Y made a report to the police alleging 13 years of violence perpetrated by Mr. Y, that he assaulted her and the children when he was drunk and that he had sexually abused both Sibling 2 and Sibling 3. She reported that the children were frightened of their father and were too scared to make a disclosure. This was one report, in a series of allegations. Between June 2012 and the 1st of July 2015 (when the time line for this review begins) there were 19 different allegations of abuse made by mother, household visitors, neighbours, teachers, anonymous referrers as well as direct disclosures made by the children. These allegations and disclosures are discussed further in the Multi-Agency Learning.

Agency Analysis and appraisal of response during this period.

6.9 Individual Management Reviews were provided by each of the key agencies, these reviews analysed the involvement of services during this time and identified learning to be taken forward in the respective agencies. The following is a summary of the key areas identified within these reports:

- **Children Services:** Poor consideration of the family history, lack of robust supervision and challenge from managers about the response to allegations and disclosures of abuse. No evidence that the children were seen alone
often enough, lack of analysis and no evidence of professional curiosity. Insufficient consideration of the individual needs of family members, and the impact of domestic violence. A perpetual narrative that father posed no risk to the children.

- **Schools:** Overall, the children were provided with a significant amount of support in terms of their learning, social and emotional needs. Many of the concerns identified at school were appropriately referred onwards, although there were 2 occasions when there was a delay. It was not possible to establish how some of the concerns were followed up with respective agencies, and there were missed opportunities to challenge father more assertively about his care of the children.

- **Health:** Community Cambridge Services and Norfolk and Suffolk NHS Foundation Trust: The children’s health issues (particularly Sibling 3 and Sibling 4) required greater priority by health professionals involved. Despite the children accessing a range of health services, there were no clear plans to monitor and review the children’s health. There was a lack of curiosity about family circumstances, and no consideration of the family needs as a whole. In terms of the health visiting and school nurse services; overall there were poor recordings of assessments, few planned interventions, and a reactive response to the children’s needs. Of note was the absence of challenge to decisions taken by Children Services.  

- **Norfolk Constabulary:** Inconsistency in how the background information was checked meant that not all relevant information was routinely reviewed, or available to officers/ multi-agency services. The approach taken to the allegations made by Mrs. Y was influenced by a strong belief that these allegations were malicious, this was not challenged. The emphasis on seeking evidence of physical abuse solely through direct disclosure, meant that other potential sources of evidence were overlooked.

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5 It was understood that these issues have been identified in previous SCR’s in Norfolk and are being addressed in the current service redesign programme.
7. **Events under the Timeline: 1\textsuperscript{st} July 2015– 30\textsuperscript{th} September 2016**

This section covers the events over the scope of the review, including the voice of the children. Further analysis and learning is included in Sections 8 and 9 of this report.

**Summary of service involvement and analysis**

**Sibling 5 (6 years) and Sibling 6 (3 years) – GP involvement, concerns at school and MASH response**

7.1 In early July 2015, Mr. Y telephoned the GP practice and spoke to a GP about Sibling 6. The GP appropriately asked for Sibling 6 to be brought to the surgery for a face to face appointment, Mr. Y took Sibling 6 to the surgery that day. On examining Sibling 6’s ear, the GP considered that Sibling 6 may have an ear infection. The GP did not know the family history, although Sibling 6 had been frequently brought to the surgery over the past three years\(^6\) for minor childhood illnesses. The GP decided to undertake a full body examination of Sibling 6 and this was good practice. On examination, small bruises and abrasions were noted on Sibling 6’s body. Mr. Y described Sibling 6 as *very active*, and his explanation fitted with the bruises seen. An ear infection was diagnosed (otitis media apyrexial) and Sibling 6 returned home with his father. This was an unremarkable consultation, there was no reason for the GP not to believe father’s account or to be concerned.

7.2 However, 3 months prior to this appointment, Sibling 5 had told a member of school staff: *sometimes daddy punches me and sometimes punches my brothers and sisters.* Sibling 5 described his father *giving him dead legs and arms.* This had been the second disclosure of physical harm by Sibling 5 within the last year. In the previous year, Sibling 5 had disclosed that his father had bitten him; at that point (2014) the school had contacted the MASH\(^7\) and the headteacher was advised that, as there was no obvious injury, the headteacher should speak to father; no further

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\(^6\) 44 consultations had taken place involving 12 different GP’s and 7 different practice nurses

\(^7\) Multi-Agency Safeguarding Hub
action was taken by MASH. (There were no recordings found about this discussion on the Children’s Services electronic recording systems – the reasons for this are explored in the additional learning.) As a result, in 2015 when Sibling 5 spoke about being punched, and there was no obvious injury, father was contacted and in line with MASH advice previously received no contact was made with MASH.

7.3 It is the view of the Review Team that this response did not meet the needs of the children. The advice the school had received from MASH (i.e. where, unless there was a visible injury, MASH would not be involved, and the school were to contact parent) set a concerning precedent. Had there been involvement from MASH in the form of an investigation under Sc47, the GP would have been aware of the involvement of other agencies and the bruises seen on Sibling 6, and the explanation given, may have prompted greater curiosity.

Section 37 Court Report
7.4 Later that month, Mrs. Y contacted a solicitor in an attempt to gain contact with her children. She reported concerns about the care father was providing to the children (including concerns about his abuse of substances). After an initial court hearing, Norfolk Children’s Services received a Court Order requesting the completion of a Sc37 investigation. In line with expected practice, a strategy discussion was held in MASH involving the police, Children’s Social Care, the school nursing service, and the health visiting service. The history of agency involvement was shared, and it was noted that there were no concerns about the care provided by Mr. Y.

7.5 A decision was taken that a single agency report would be completed, and the case was passed to a Social Work team. This discussion did not include the information shared by Sibling 5’s school about father biting him. It was understood that the reason for this was because at the time this would have been regarded as

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8 When a request for a Section 37 report is received there needs to be an analysis of the reasons why it has been requested and a decision made as to whether it meets the criteria for a Section 47 investigation and Single Assessment or just a Single Assessment. In all cases a request for a Section 37 report requires, as a minimum, that a Single Assessment is completed.
‘consultation’ not a referral, and so was not recorded in the MASH data base. In addition, as there were no discussions with Sibling 5’s school, his most recent disclosure of physical abuse was not shared. Relevant issues are discussed in the Additional Learning.

7.6 During August 2015, the allocated Social Worker visited the family home. The children were seen together at home where Mr. Y was present. The recording made about this visit is confusing: the names of the children are muddled and so it is difficult to establish what was understood about the individual wishes and feelings of the children. (The perspectives of Sibling 1 and Sibling 4 are relevant to this visit, and are discussed later in this report).

7.7 A telephone conversation took place with Mrs. Y and a Child In Need (CIN) meeting, involving representatives from health and the children’s schools, was recorded as taking place. The report submitted to court stated that there were no concerns about paternal care and concluded that the children did not wish to see their mother; it was asserted that the court process was causing distress to the family. A conclusion was reached that the numerous allegations which have been investigated and proved false was distressing for the family, and a recommendation was made that the children had monthly telephone contact with their mother.

7.8 Contrary to legal requirements and local procedures, the report was not informed by a core assessment and did not contain information about the individual needs of the children. The agency report provided by Children’s Services for the purposes of this SCR provides an accurate analysis of the quality of this report, including (but not exclusive to):

- Lack of proper analysis of family history
- No reference to previous sexual abuse allegations against Mr. Y
- Minimizing the disclosures made by the children (and allegations made by third parties) of physical and sexual abuse and use of misleading language when referring to these allegations

9 19 direct and indirect allegations made by a 3rd party and disclosures by the children of sexual and physical abuse
- Lack of any reference to whether Mr. Y was misusing drugs and alcohol (despite this being a specific request from the court).

7.9 It was understood that the quality of this report was not representative of the standard of reports usually submitted, and service training has strengthened practice in this area. As a result, no wider learning has been identified about Sc37 reports. However, observations made within the Children Services Report have wider implications for safeguarding children in Norfolk: *This (court report) appears to perpetuate the narrative that Mrs. Y presented as the most concern regarding her behaviour and parenting and this is seen from the first involvement with the family.*

7.10 In addition, the Children’s Services single agency SCR report correctly highlights concerns about the use of language within the Sc37 report and throughout the history of Children Services involvement: *Minimising language regarding allegations and disclosures is seen throughout the recording.* This was seen across a range of multi-agency recordings during this SCR, and has significant implications on how the experiences of children are understood.

**CAMHS & GP Response to Sibling 2.**

7.11 In November 2015, Sibling 2 (then aged 14 years) was seen with her father by a GP. Superficial cuts were observed, believed to be caused by Sibling 2 self-harming with a blade. Sibling 2 said the reason for her self-harming was because she was being bullied at school, and that her school were aware. The GP recorded that Sibling 2 had *poor sleep* and that *her moods are up and down*, and a decision was taken to refer to CAMHS. It appears from the records that Sibling 2 was seen in the presence of father; it's not recorded whether she had been given an opportunity to be seen alone. Expected practice in these circumstances is that a child of this age is given the opportunity to be seen without parental presence and this should be recorded in the patient’s notes.

7.12 Three weeks later, the GP practice received a letter from CAMHS confirming that a letter had been sent to Sibling 2 requesting that she contact the service and informing Sibling 2 that: *(we)* *will assume that if no contact is made within 10 days that you do not need help.* As no contact was made, CAMHS took no further action.
and closed their involvement. There was no subsequent follow up by the GP practice, this fell below expected practice. It is the view of the Review Team that the wording used in this letter is unhelpful. To assert that a 14-year-old child would have sufficient motivation and resources to respond to such a letter, is an unreasonable assumption. Children who are self-harming are at minimum displaying help seeking behaviour and are in need of help and support; it is not that the child does not need help, it is more likely that the service cannot (for whatever reason) respond to the child’s needs in a way that meets their needs.

**Multi-agency Response to Sibling 3 and Sibling 2.**

7.13 In May 2016, whilst at school, Sibling 3 was overheard speaking to a friend referring to her father punching her ear. Sibling 3 was noted to have a bruise on her ear. A body map was completed, and a prompt referral was made to the police; this was good practice. School records note that Mr. Y was interviewed by the police that day and Sibling 3 was seen. Both denied any abuse. No entries could be found in the Children’s Services electronic recording system regarding this referral and response. The referral was made directly to the police, rather than MASH, because of the nature of the assault. It is unclear why the police responded as a single agency, why no report of this injury and the investigation was reported to MASH and why no report was made on the police data base of their response.

7.14 Two days later, police received a call from a parent of Sibling 2’s friend reporting that Sibling 2 had a black eye and that she had alleged her father had punched her. Police responded by visiting the home address and recorded: *Sibling 2 was spoken to in the presence of her father.* They concluded: *It was established that Sibling 2 did have a faint black eye caused by a trampolining accident.* No discussion took place with either the referrer or Sibling 2’s friend. Had they been included in the investigation they may have known that (in the words of Sibling 4): because of their fear of father *[Sibling 2] told her friend to phone the police so he [father] wouldn’t know the call had come from her.*

7.15 Two days after that, a contact form (C39d) was received by MASH reporting this visit and concluding: *Sibling 3 did have a faint black eye but corroborated*
father’s explanation that it was a trampolining accident. No Further Action (NFA) was taken by the police or by MASH.

7.16 The police recorded response confused the names of Siblings 3 and 2, and caused some confusion for the Review Team. A position was taken by the Review Team that these recordings related to one incident, and there was just a confusion of names. On further scrutiny of the records, it was clear that this was not simply a confusion of names – it was a confusion about two separate and distinct allegations of abuse: one in relation to Sibling 3 being punched by her father and having a bruised ear, and one in relation to Sibling 2 being punched by her father and having a bruised eye. The responses to these allegations was highly confused and confusing, and the investigation of these injuries was poor. Neither child was seen alone, the account given by Mr. Y was accepted without question, Children’s Services simply recorded their systems, no challenge was made, no multi-agency response was provided, and no further action was taken. This response fell well below expected practice and procedure, and left the children at risk of further harm.

**The perspectives of Sibling 1, Sibling 4 and Sibling 3.**

7.17 When speaking to Siblings 1, 3 and 4 as part of this SCR, they spoke of how their father would “put on a good show” when professionals visited the family and that they had to “play happy families…Dad was good at hiding things.” They spoke of being “told to lie” about their injuries and about their fear of father. Sibling 4 recalled the visit made by police officers on this day: he said he had a black eye as he had been punched by his father and that his father had told him to say it was an accident: “I had to lie and say I slipped”. When the police visited the family, Sibling 4 felt strongly that he did not want to lie to the police (Sibling 4 has an ambition to be a police officer when he is older: “so that I can protect children”) and so covered half of his face with his dressing gown to avoid scrutiny. He was not spoken to by the officers.

7.18 Siblings 1 and 4 spoke about their father telling them that if any of the children spoke about what was going on at home “he would find them and kill them all”. Because of the extent and duration of the violence witnessed by the children (perpetrated by their father on their mother, household visitors and each other), it is
perfectly understandable that his threats were believed. There was a belief held by the children that if they told, they were risking their own life and the lives of their brothers and sisters.

7.19 When Siblings 1, 3 and 4 were asked about what services could have done to help them, Sibling 3 said: “they shouldn’t have always believed him” [father]. Sibling 4 said: “they [children] need to be a in a separate room with someone they trust to tell them what’s happening otherwise they [professionals] think there’s no-one to tell.” These responses reflect simple wishes, and it is reasonable to conclude that in drawing from their experiences (and that of their sister and brothers) Siblings 1, 3 and 4 were speaking on behalf of other children in similar circumstances.

Safeguarding the sibling group

7.20 Just over a week later, a friend of the family contacted the school to report physical abuse of the oldest three children. Sibling 2 was spoken to by the Safeguarding Manager in the school and confirmed that her father had assaulted her by thumping her in the face, causing a nose bleed. She said Sibling 1 had intervened, which resulted in a fight (Sibling 1 was observed to have visible scratch marks on his neck). The referrer confirmed that two weeks previously, Sibling 3 had a bruise on her ear which Sibling 3 now said was caused by her father. MASH was immediately contacted, and Sibling 2 was supported to give a clear account of events. A strategy meeting took place, and all the children were seen separately at their schools by a social worker and police officer. All confirmed physical abuse by father, and spoke about his use of drugs and alcohol.

7.21 The children were placed with the family friend overnight, and the case was passed to the Children’s Services assessment team for completion of a Sc47 (child protection) investigation. The multi-agency response to achieve the immediate protection of the children was timely and appropriate. However, no child protection medicals took place and, given the extent of the disclosures made by the children (who all spoke about being punched, strangled, kicked, slapped and pinched), child protection medicals were clearly indicated.
7.22 On the next day, father was interviewed by the police. He said he had been drunk on the night in question, and gave an account of events. He skillfully framed the abuse as *play fighting*, or a response to their *naughty behaviour*. Father was given two conditional cautions for common assault\(^\text{10}\) with conditions that he comply with treatment for his alcohol misuse, and fully engaged with Children’s Services.

7.23 On the same day, the Social Work assessment was started. This assessment recognised some of the historic concerns in the family, the risk of ongoing physical and emotional harm, concerns that children were covering up for their father *and will not make disclosures*, and concerns about the *overt parental control* and *disguised compliance* by father. Although the assessment did not overtly consider the risk of sexual abuse, it was a reasonable early assessment of the risks in this case. However, the reference to the abuse of the children as *physical chastisement* minimised the abuse the children had suffered and were likely to suffer, and the recommendation that the family should be provided with services as CIN (as opposed to child protection) was not proportionate to the risks. In addition, this was a joint Sc47 investigation, the decision about how to proceed should have been discussed with the police but this did not appear to happen.\(^\text{11}\) This was contrary to the key principles enshrined in safeguarding legislation and procedure that require multi-agencies to share information and decision making.

7.24 Later that day, two recordings were placed on files marked as ‘Management Overview’. The first stated that Mrs. Y would not be part of the assessment. The reasons given for this decision were because of:

- *historical parental conflict*
- the children did not want contact with her and
- the current involvement of Children’s Services in relation to Mrs. Y’s child (with her new partner).

The reasons for this decision were understandable, but they were not justifiable. There was a long history of Mrs. Y raising concerns about father’s misuse of alcohol and drugs, and of the physical and sexual abuse of the children. It was the view of

\(^{10}\) Common Assault, contrary to section 39 Criminal Justice Act 1988. An offence of Common Assault is committed when a person either assaults another person or commits a battery.

\(^{11}\) According to the records held within the police, the risk level to the children was classed as ‘high’
the Review Team and practitioners that this decision was influenced by the fixed views held about the family.

7.25 The second entry on the data base was a management decision that the children would return to father’s care the next day and that an Assistant Practitioner would visit the following evening. The manager recorded that referrals would be made for ‘Home Based Support’ (HBS) and ‘Outreach’, that a ‘Rapid Network Meeting’ would take place and a ‘Safety Plan’ put in place.

7.26 Despite the significant concerns, the four youngest children returned to father’s care the next day. Siblings 1 and 2 remained with the family friend. Father had not been seen by a Social Worker, the children had not been spoken to about their views, no support had been put in place, there had been no multi-agency meeting, no child protection medical and no safety planning. It was not clear when the referrals were made to the HBS and Outreach teams and no evidence was found that a Rapid Network Meeting took place nor that a Safety Plan was discussed with the children, with father or with other professionals. The lack of action taken to safeguard the children and the prompt return of the children to father’s care, placed the children at risk of further significant harm and fell well below expected practice.

7.27 In the words of Sibling 4: “Kids need to trust that they [Social Workers] will do something, that they can protect them…they should take kids away until they can make sure everything is okay [at home]”. By returning the children the following day without proper checks being made undermined the children’s confidence in adults’ ability to keep them safe.

7.28 It was the view of the Review Team and practitioners that there were several factors influencing the decision making at this time. The issues explored in the Multi-Agency Learning about working with perpetrators of abuse, holding a fixed view of a case and the issues explored in the Additional Learning in relation to shared multi-agency decision making are relevant.

The involvement of the Assistant Practitioner, the Family Intervention Team and the Home-Based Support Team.
Seven days later, an Assistant Practitioner (AP) visited the family. This practitioner had been given a specific task of completing a Signs of Safety (SOS)\textsuperscript{12} Mapping exercise with all six children. Sibling 1 was still living with the family friend, but all the other children were at home with their father when the visit took place. The Assistant Practitioner was not a qualified Social Worker and it was unreasonable to expect that this initial visit would include seeing the children individually, or to challenge father about the physical abuse or to assess current risk. The lack of Social Work intervention since the children had returned home, the absence of a safety plan and the absence of a multi-agency meeting, left this worker in an untenable position. That said, the Assistant Practitioner completed the task well, using a helpful evidence based working tool.\textsuperscript{13} For the first time the children were provided with a space and an opportunity to collectively talk about their worries and their safety, albeit with their father present in the home.

The Assistant Practitioner viewed all the rooms in the house and observed that the conditions appeared reasonable, father did nothing to obstruct the work with the children, and the bond between the children appeared strong. But she felt *something was not quite right* – this was a gut feeling; her impression of Mr. Y was that he was *over the top – compensating*, and his responses were *not natural*. She observed Mr. Y embracing Sibling 2 after she returned home and noticed Sibling 2 did not reciprocate, she looked *cold and rigid*.

These were important observations that needed to be explored with an experienced practitioner/manager, and reflected on. The Assistant Practitioner was very new to her role and whilst there was a good relationship between her and the allocated Social Worker, they were based in separate teams and had different line managers. She received no supervision over this time, no space was provided by a manager to allow her to reflect on this visit, and no management guidance was provided. It is understood that the supervision and management of Assistant Practitioners has been strengthened, as a result no relevant lessons are included in this review.

\textsuperscript{12} The Signs of Safety is an innovative strengths-based, safety-organised approach to child protection casework.

\textsuperscript{13} Signs of Safety Assessment and Planning (Mapping)
7.32 Two weeks later, the Social Worker and a member of the Home-Based Support Team visited the family home. The Social Worker was clear that the family required ongoing involvement from Children’s Services and successfully challenged a management view that the case should be closed, this challenge was good practice. Shortly after this, a Children Services manager recorded a decision to pass the case to a Child in Need (CIN) team.

7.33 The following period was significant in influencing the course of subsequent events.

7.34 After a CIN meeting at school, the case was passed to the Family Intervention Team (FIT). Once this happened, there was a significant increase in Children’s Services involvement. Newly allocated staff reviewed the case history resulting in a renewed focus and urgency to the services provided.

7.35 The FIT Social Worker spoke to the previous Social Worker from the assessment team and the Assistant Practitioner. She was aware of the previous allegations of physical abuse and of Mr. Y’s misuse of drugs and alcohol, and felt a sense of urgency to understand what was going on in the family. A prompt initial visit was arranged to see the children at home. Mindful of the number of Social Workers that had been involved with the children in the past, the Social Worker sent the children a booklet about herself titled ‘This is Me’.

7.36 During the visit, the Social Worker met with the children, spoke to father and looked at the children’s bedrooms. The purpose of this visit was to start to build a trusting relationship with the children and to make an early assessment. This was an entirely appropriate focus. Whilst nothing of obvious concern was apparent, the Social Worker was worried: she noticed that the children were quiet and did not speak unless spoken to. The Social Worker was attuned to her own gut feelings and felt the house had an eerie, uneasy feel.

7.37 Shortly after this visit, she received prompt supervision from her line manager. During supervision, she appropriately discussed the visit and the feelings she was left with. The manager raised concerns about possible disguised compliance by Mr.
Y, and the risks to the children of sex offenders in the family network. The Social Worker was instructed to review past files and to be curious and tenacious in their work with the family. The importance of strong, challenging and reflective supervision cannot be overstated: the management support and guidance that was demonstrated illustrates a critical tenet of the safeguarding system and can make a significant difference to how children are safeguarded.

7.38 In 1-2-1 meetings between the Lead Reviewer, the Manager and the Social Worker, it was clear that the supervision routinely provided by this manager features curiosity, challenge and reflection. In addition, at that time both the manager and the Social Worker had recently attended training to improve their knowledge and skills in safeguarding children who may be the victims of sexual abuse. This training was commissioned by Children’s Services in response to recommendations from a previous SCR.\(^1\)

7.39 On the same day supervision took place, a Home-Based Support (HBS) practitioner visited the family home. During this visit several parenting issues were discussed, and for the first time the children were present when their father was challenged about his parenting; including his disproportionate methods of managing Sibling 4’s behaviour. The HBS practitioner was concerned about father’s reaction to this challenge, and properly noted these concerns. The HBS practitioner was right to challenge father in the presence of the children.

7.40 From the perspectives of Siblings 1, 3 and 4, witnessing this challenge was important to them. They all spoke about a friend of the family who would visit and would challenge their father about his parenting and when they remembered this person, it was in the context of speaking about adults they could trust. When Siblings 3 and 4 spoke about this person, a smile lit up their faces. Sibling 4 said: “He was good at sticking up for us, he would tell dad not to hurt the kids and be a better dad.” and Sibling 3 said: “It made me feel happy when someone stuck up for us.”

\(^1\)NSCB Serious Case Review, Child P (2016)
7.41 On the Friday of the same week, Sibling 4 sought out the Safeguarding Manager at school with whom he had a good relationship. He said his father had pushed him onto Sibling 3, causing his neck to hurt; Sibling 3 confirmed this account and the Social Worker was contacted. The Social Worker spoke to her manager and responded saying a visit would take place next week. It would have been expected practice for the children to have been seen that day; it is unclear why this did not happen.

Sibling 4 Discloses.
7.42 On the following Monday, Sibling 4 again sought out the Safeguarding Manager at school. Sibling 4 disclosed that his father had hit him the day before and started to cry. He went on to disclose that father had hit both of his sisters on Saturday night, and that Sibling 3 had told him father had raped her. The Safeguarding Manager saw Sibling 3 straight away, Sibling 3 confirmed that both she and Sibling 2 had been raped.

7.43 When Sibling 4 was seen during this SCR he said: “I wanted Dad to change but he didn’t.” Sibling 4 decided to tell his teacher the day before he went to school: “When I realised that if social workers couldn’t help, nobody else was going to change him.”

Child Protection Investigation and Response.
7.44 An immediate strategy meeting was held and ABE\textsuperscript{15} interviews took place. Extensive disclosures were made by the children of recent and historic sexual and physical abuse, stretching back over several years. All six children were removed from the home and placed with a trusted friend of the family. Mr. Y was arrested and charged with 11 offences, including 9 counts of rape. Subsequently, Mr. Y pleaded guilty to the offences and was sentenced to life imprisonment.

Sibling 1’s Perspective

\textsuperscript{15} Achieving Best Evidence: Good practice in interviewing witnesses, including victims, to enable them to give their best evidence in criminal proceedings.
7.45 Sibling 1 recalled that when he was 12 years old, he had run away from home and told his mum that Sibling 3 (10 years) was being sexually abused by their father. He confirmed this in a police interview, recalling how he had witnessed sexual acts perpetrated by his father on Sibling 2 whilst living in Coventry,\textsuperscript{16} and on Sibling 3 when living in a caravan in another area.\textsuperscript{17} Sibling 1 said nothing was done,\textsuperscript{18} and he feels angry about this. He said "People [professionals] could have done more. I wanted what happened later, to happen then."

\textsuperscript{16} When Sibling 2 was 10 years or under
\textsuperscript{17} When Sibling 3 was 9 years or under
\textsuperscript{18} Police interviewed Sibling 2 and Sibling 3 who both denied the abuse
8. Multi-Agency Learning and Recommendations

8.1 How are we able to assess that on the balance of probability that a child is the victim of sexual abuse and how can we successfully safeguard a child when no formal disclosure has been made?

8.1.1 The damaging effects of sexual abuse, and the barriers children face in disclosing sexual abuse has been the subject of a range extensive research and literature, and has been detailed in recent SCR’s in Norfolk. The consensus of this research and literature is that sexual abuse is largely hidden and can be difficult to uncover.

8.1.2 The Office of the Children’s Commissioner (OCC) commissioned a rapid evidence assessment into child sexual abuse in the family environment in 2014 which showed that 1 in 20 children in the UK have been sexually abused, 90% by someone they knew. However, as identified in the NSCB sexual abuse strategy:

Of the 43,000 children in England who are subject to a child protection plan at any given time, only around 5% are on a plan for sexual abuse.

8.1.3 In research published by the OCC in April 2017 more evidence is cited on services provided. Some of the key points relevant to this case include:

- Professionals are often failing to pick up the signs of child sexual abuse, unfairly placing the responsibility on victims to make sure their abuse is identified.
- Teachers feel confident identifying the signs and symptoms of child sexual abuse, but concerns raised with local authorities are much more likely to be acted upon if a child has made a clear disclosure.

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20 Other research places this figure much higher: Research by Radford (Radford et al 2011) suggests that nearly a quarter of young adults (24.1%) experienced sexual abuse (including contact and non-contact), by an adult or by a peer during childhood.
21 http://www.norfolklscb.org
8.1.4 The scale of this abuse, the long-term effect on the mental health and wellbeing of children and adults (particularly if it remains undisclosed for many years) and the reliance on children to disclose, makes safeguarding children from intra-familiar sexual abuse extremely challenging. That said, the experiences of the sibling group in this family highlights some important learning for practitioners and services.

8.1.5 Firstly, this case highlights the importance of understanding the family history. The history of Mr. Y showed that on two separate occasions an adult and two children had disclosed to the police that he had raped them. Further disclosures of sexual abuse were made by Sibling 1 and allegations of sexual abuse were made by members of both the paternal and maternal family. Some of these disclosures were investigated by the police, but no convictions were successfully brought.

8.1.6 The reasons for this lie partly in the difficulties in establishing a sound evidential base in cases of sexual abuse, and partly in the issues explored in Question 8.4 (below). But on the question of whether the children were at risk of sexual abuse, the fact that no successful criminal prosecution was brought and the fact that no direct disclosures were made, is largely irrelevant. The burden of proof in criminal law requires judgements to be made on the threshold of ‘beyond reasonable doubt’. In safeguarding children, the evidential threshold of proof is ‘the balance of probability’. Given the history of Mr. Y, the known existence of Sch. 1 offenders within the kinship, the contact these Sch. 1 offenders were having with the children and the vulnerabilities of these children (including an extensively transient early life, domestic violence, and substance abuse by Mr. Y), a judgement should have been made at several points across the lengthy period of multi-agency involvement that on the balance of probability, there was a strong likelihood that the children in this family were at risk of sexual abuse.

8.1.7 This was discussed with practitioners at the Learning Event. There seemed to be a consensus that insufficient weight is placed on the concept of likelihood of harm, when safeguarding children from sexual abuse. Instead, there is an emphasis of
‘waiting for a disclosure’ before taking decisive statutory action\(^{23}\) to safeguard a child. The reasons for this were said to be an over reliance on the criminal threshold for decision making about the levels of risk in families and so if the police did not pursue with a criminal case, the risks to the children were seen to have diminished. This provides a partial answer to the terminology seen in recordings within the Children Service’s case file regarding the disclosures and allegations about sexual abuse.

8.1.8 As identified in the Children’s Services single agency report completed for the purposes of this SCR:

_Throughout the period October 2011 to the present day there have been five indirect disclosures or concerns made by third parties relating to (name of father) sexually abusing his children (and a clear disclosure from Sibling 1 in Nov 2012). When referring to these allegations words used such as deemed as unfounded\(^{24}\) with no further action from Children’s Services were misleading, the allegations and disclosure were unable to be criminally substantiated, not proven to be untrue._

8.1.9 The second key area of relevant learning is on the issue of trust. In the words of Sibling 4: “Kids need to be a in a separate room with someone they trust to tell them what’s happening otherwise they (Social Workers) think there’s none to tell”.

8.1.10 There were very few occasions when Social Workers saw the children either individually or outside the family home. Siblings 3 and 4 were clear that in the presence of their father, whether he was in the room or not when police officers and Social Workers visited, they would not have spoken about the abuse. Guidance and procedure is clear: children should be given the opportunity to be seen alone by Social Workers and police officers and this is basic safeguarding practice is undisputed. However, it is the view of the Review Team that if the children had been seen alone, it would have been unlikely that a disclosure of sexual abuse would have been made and, given the fear they felt from their father, even if the children were seen alone by these professionals outside the family home, a disclosure would have been unlikely.

\(^{23}\) Such as conducting a Sc47 investigation, making a child the subject of a CP plan, initiating care proceedings.

\(^{24}\) Having no foundation or basis in fact
8.1.11 It is important to note that Sibling 4 refers to the need for children to be with someone they trust, and this is a crucial distinction. When Sibling 4 was asked what made him trust the Safeguarding Manager at his school he said: “She was nice…she knew, but she didn't know.” The trusting relationship this member of staff built with Sibling 4 and his siblings at the school was critical, and so when the foundations of a platform for disclosure had been laid (as below), this opened the door for Sibling 4 to disclose to his trusted adult.

**Building a platform for disclosure**

8.1.12 The phrase ‘building a platform for disclosure’ was used by a practitioner during this SCR, and the Review Team felt that this is a fitting description of the work that took place prior to the disclosure made by Sibling 4. The prompt and decisive action taken in response to the disclosure of physical abuse by Sibling 2 laid the first foundation of this platform (albeit that the children were prematurely returned to the family home). This demonstrated to the children that professionals were prepared to challenge Mr. Y’s power and control, and could do so. This was critical, the children had been living for many years with a father who was extremely violent and controlling and who from their perspective, and from evidence found during this SCR, was able to control the decision making of professionals. The increased involvement of practitioners in family life that followed, was a new experience for the children. For Sibling 4, this enabled him to start doubting the threats that father had made to find them and kill them: “I knew we would probably be protected in social services’ hands.”

8.1.13 There were several significant events that were important in creating relationships with the children that increased the trust they had in professionals’ ability to protect them, and so increased the possibility of disclosure. The following interventions were particularly significant, set out in the order they happened:
- The SOS\textsuperscript{25} mapping completed by the Assistant Practitioner that enabled the children to think and talk about some of their worries, and most importantly to visualize and name their safety network (their trusted adults).

- The preparations made by the FIT Social Worker before meeting the children, when they were sent a booklet describing herself as a safeguarding professional (with a duty and power to protect children) and importantly - a person.\textsuperscript{26} This simple but effective way of connecting with the children was important and a good first step in building the foundations of a trusting relationship.

- The overt challenge to father’s care and use of control, by the HBS practitioner in the presence of the children in the family home, that challenged the long-standing belief held by professionals that father was compliant with services and demonstrated to the children that professionals were prepared to challenge him.

- The reflective supervision provided by the FIT manager that questioned the prevailing view of family functioning (informed by the specialist sexual abuse training provided by Norfolk Children Services in response to a recommendation in a relevant SCR).

**Building a trusting relationship**

8.1.14 There were many examples throughout the history of services involvement that demonstrated how a trusting relationship had been built by members of staff across the three schools attended by the children and it was within these relationships that the children disclosed the physical abuse they were suffering and ultimately, the sexual abuse.

8.1.15 The relationships between the children and school staff were characterised by genuine care and compassion. The children were given many opportunities to see

\textsuperscript{25} Signs of Safety
\textsuperscript{26} As described by the SW: *it makes me human and this is particularly important for children who have had a lot of SW’s.*
staff alone, when they would be listened to and their voices heard. The children felt confident in these relationships and so when Sibling 4 said that the Safeguarding Manager at his school knew but, didn’t know, on the surface seems simple, but it is not. Sibling 4 was given frequent opportunities to speak with this member of staff and trust was built on the day to day care and attention she paid to his wellbeing and that of his siblings. In building this relationship Sibling 4 understood that she was able to hear his disclosure, to believe him and take action.

8.1.16 For Sibling 3, knowing that you are being listened to means: “people will do something about your feelings.”

8.1.17 The work of this member of staff cannot be commended highly enough and demonstrates that trusting relationships with children have the best chance of being formed with professionals who are present within their day to day lives. However, for members of school staff to be effective in building this trusting relationship there needs to be a commitment within the school to provide capacity for staff to commit the time needed to build these relationships so that children can be listened to, and their voices heard. This commitment was clearly present in the secondary school the children attended in Norfolk, where full time non-teaching members of staff are employed in these safeguarding roles. However, there is limited support available to staff in these positions, such as reflective supportive supervision. The role of schools in safeguarding children was the subject of quite lengthy debate and is discussed further in the Additional Learning.

Finding
The NSCB are encouraged to draw on the learning in this section, particularly around using clear, open and accurate language to prevent minimising concerns and demonstrate professional curiosity. The Board should consider formulating a multi-agency practice model to inform their work with children who are at risk of Child Sexual Abuse (CSA).

Recommendation 1: NSCB to:
- define and map a practice model, in line with the Signs of Safety approach, for using family history to identify risk and likelihood of sexual abuse, to include seeing children on their own, building trusting relationships and platforms for disclosure;
- prevent minimising concerns by encouraging professionals to be descriptive about what they are observing and recording their professional opinions; and
- audit cases to test how widely the model is implemented.

8.2 How effective are we at disseminating learning from previous SCRs where sexual abuse was a dominant feature and what impact did this have on the way we managed this case?

8.2.1 There was evidence found that the workforce in Children’s Services were aware of recent SCRs and the learning that had emerged. Staff talked about the impact this had on their practice. This was starkly highlighted in the response of the manager and Social Worker in the FIT team: they were both clear that the training they attended, commissioned in response to the recommendations from a recent SCR, raised their awareness of CSA, influenced their practice, and better equipped them to safeguard children.

8.2.2 There was strong evidence that practitioners in Children Services and members of school staff were aware of previous SCRs, had often read the reports, attended briefings and relevant training. The impact of this learning was less evidenced across all multi-agency partners. Multi-agency members of staff from health and police spoke about not having time to read SCRs, had not attended relevant briefings and as a result were not routinely integrating the learning into their practice.

8.2.3 The NSCB website provides a very comprehensive summary of SCRs in an accessible power point format and are pro-active in promoting the priorities of the board, based on the learning from SCRs, through clear and comprehensive strategies, and learning and development plans. More recently, the NSCB has focused on tackling

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27 Child Sexual Abuse: Understanding and Working with Sexually Harmful People and Victims
28 NSCB Serious Case Review Child P (2016)
CSA and the website demonstrates a creative and accessible approach to disseminating research, promoting best practice, and raising awareness of professionals, parents and children. The NSCB strategy is informed by a wealth of knowledge and experience, gained from reputable experts in sexual abuse.\textsuperscript{29} It is still early days in the implementation of this strategy but based on the recent practice in this case, the value of this focused approach in strengthening the safeguarding of children is clear.

**Findings:**
The Board has taken a pro-active response to prevention, identification and interventions required to better tackle CSA as result of learning from previous SCRs. The implementation of the NSCB CSA strategy requires further monitoring to ensure all agencies are taking appropriate action.

**Recommendation 2**
NSCB to evaluate the impact of the current CSA strategy across agencies and strategy workstreams in order for progress to be measured. This to include all agencies demonstrating how they disseminate learning form SCRs through the Section 11 process.

8.3 How well do we understand the behaviour of perpetrators and how does this understanding influence our work with children?

8.3.1 From the perspective of professionals who knew Mr. Y, he was described as pleasant, a charming man and a good dad. From the perspectives of the children spoken to: “He told us to play happy families when people visited- we were used to doing it. He was good at hiding stuff, he lied about everything. People thought that dad was a good dad, but he fooled them … they thought he was a nice dad instead of a rubbish dad.”

\textsuperscript{29} Such as The Lucy Faithful Foundation (The Lucy Faithful Eradicating Child Sexual Abuse Framework), the NSPCC etc.
8.3.2 When working with families where there are concerns about child sexual abuse, it is crucially important to understand the behaviour of perpetrators; this allows services to better understand the impact of perpetrators’ behaviour on children and on professional decision making. However, whilst there was available information to suggest Mr. Y was a perpetrator of sexual abuse, for the reasons explored in Question 8.1 (above) and Question 8.4 (below) he was not regarded in this way, so father’s behaviour was not understood using an informed framework about how perpetrators may operate.\textsuperscript{30}

8.3.3 As stated, CSA is largely hidden and difficult to detect. Using a specific framework for understanding perpetrators’ behavior,\textsuperscript{31} can be very helpful in safeguarding children from sexual abuse. However, as this case demonstrates, in the absence of previous convictions, it is unlikely that such a framework would be used. There was strong evidence that the training commissioned by Children’s Services for their staff in response to a previous SCR contributed to their overarching understanding of CSA, including risks, indicators and family history of CSA offences.

8.3.4 The more relevant learning from this case is in relation to Mr. Y as a perpetrator of violence. He had received two convictions for violence against Mrs. Y and this violence\textsuperscript{32} was regarded by the police as \textit{prolific}. Terms were used in case recordings that referred to this violence as \textit{domestic conflict} or \textit{domestic dispute}, and his abuse of the children as \textit{physical chastisement} or \textit{rough play}. This minimised the violence and diverted professional focus away from Mr. Y as a perpetrator and, when combined with Mr. Y’s evident capacity to manipulate and influence professional judgement and decision making, the harm the children were suffering was not seen. This is also addressed in Question 8.4, below.

8.3.5 There was an implicit assumption throughout much of the work that the violence Mr. Y perpetrated was situational, i.e. only relevant to his relationship with Mrs. Y. The violence he perpetrated on Mrs. Y and on the children, was coercive and controlling.

\begin{itemize}
  \item \textsuperscript{30} Such as the ‘Four Preconditions model’ attributed to Finkelhor (1984).
  \item \textsuperscript{31} Although as this and other cases suggests, this is not always the case.
  \item \textsuperscript{32} The 2016 Triennial Review of SCR’s (Brandon et al 2016) identifies the following relevant findings: Previous violence in one relationship is a reliable indicator of future violence. Domestic abuse is about power and control rather than a momentary loss of self-control. Domestic abuse is likely to be a pattern of behaviour rather than a one-off event.
\end{itemize}
The nature of this violence is dispositional, i.e. an inherent feature of a perpetrator’s character and behaviour, and therefore highly likely to continue regardless of a particular relationship or context. This was important to define and would have provided valuable information about the risks he posed, giving important insights about the children’s experiences.

8.3.6 Recent work in the USA,\(^{33}\) at The Tavistock Clinic\(^{34}\) and in Doncaster,\(^ {35}\) advocate that a more sophisticated nuanced understanding of domestic violence is required.

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\text{All of our important questions about domestic violence may be different for the different forms of violence}^{36}.
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8.3.7 Finally, when Sibling 4 was asked about what message he would like to give to professionals who might be working with children such as himself, he said: “People [professionals] should ask [parents]: ‘Why did you do that to your own kid? Do you know how that affects them, their feelings and behaviour?’” Sibling 4 is advocating that professionals need to be both curious and challenging when working with parents. This advice from Sibling 4 is a critical tenet of all multi-agency work with parents, and is particularly relevant when working with perpetrators of sexual abuse and violence.

**Finding**

Understanding the behaviour of perpetrators is critical to safeguarding work and requires further development in Norfolk.

**Recommendation 3a**

NSCB should ensure that the training Children’s Services commissioned in response to a previous SCR is included in their multi-agency training programme, to broaden

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\(^{34}\) The Tavistock and Portman NHS Foundation Trust; Tavistock Policy – Tavistock relationships, Situational Violence

\(^{35}\) Doncaster Domestic Abuse Strategy 2017-2021 (Doncaster Safeguarding Partnership)

the audience and to include links with perpetrators of domestic violence in this training module.

**Recommendation 3b**
All single agency training should include the behavior of perpetrators in their safeguarding training packages.

The NSCB Thematic Learning Framework from SCRs appropriately identifies professional curiosity and challenge with families and between professionals as a priority area for continued development. As a result, no specific recommendation is made in this area but should continue to be prioritised.

8.4 **What opportunities are available to multi-agency practitioners to consider possible prevailing mindsets and assumptions about families?**

8.4.1 A fixed view of the family seemed to prevail across the multi-agency professional network over almost the entire duration of service involvement. The universal view of the family was that this was a father who was a *hero* – coping alone with six children and was doing a *good job*.

8.4.2 Conversely, Mrs. Y was seen as problematic, incapable of parenting the children, making false allegations against father and causing distress to the father and children. As a result, Mrs. Y was never consulted about the plans for the children, or told about the investigations that took place. Her reports to the Police and Children’s Services about the abuse the children were suffering, were dismissed as malicious. When nothing happened in response to her allegations, she made two attempts to gain contact with the children through the courts and, despite the risk of violence from Mr. Y, she returned home and provided care to her children.

8.4.3 Throughout the duration of multi-agency involvement Mrs. Y maintained a level of contact with the children, attending meetings at school and taking the

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37 And it is understood from mother that she is still not consulted about the LAC plans for the children, or included in LAC Reviews.
children to medical appointments. Whilst it was understood and accepted that mother was not able to provide full time care of her children, her actions suggested that she was able and willing to provide a level of maternal care and wanted to act as a protective factor.

8.4.4 However, the prevailing view of Mrs. Y was that she was the problem, and this obscured the focus away from the risks posed by Mr. Y. This was in part reinforced by the children; in the words of Sibling 1 “Dad poisoned my relationship with Mum.” This was indicative of the level of control Mr. Y was still exerting over Mrs. Y and over the professional view of family life.

8.4.5 This was a family that was known well to the local services and so when referrals came in or allegations were made, these were interpreted within the existing view of how the family were functioning. This became a fixed view that was accepted over several years. It was only towards the end of the review period, just prior to the disclosures made by the children, that this prevailing mind set was questioned.

8.4.6 At the professional learning event, practitioners and the Review Team recognized that holding a fixed view of a case is evidenced in other families who are receiving services in the local area. It was suggested that as this locality is relatively (geographically) isolated, families can become known and known well and this can result in a particular mind set to develop about a family. In addition, the Review Team and practitioners discussed whether a gendered perception of parenting influenced this fixed view, where higher expectations are held about the parenting provided by mothers as opposed to fathers, and it was generally agreed that this may have had a part to play in how the family were viewed.

8.4.7 Having a fixed view of a case has been the subject of many SCR findings, and is discussed in the Munro Review of Child Protection\(^\text{38}\) and is a common human bias. It is a cognitive bias that can unconsiously influence our decision making so that typically we tend to make a decision based on the information that is first placed in front of us. When other information may challenge this view, we dismiss this,

\(^{38}\) The Munro Review- A Child Centred System (DfE 2011)
preferring to place greater importance on information that confirms our view, thus enabling us to hold on to our original opinions / perceptions.

8.4.8 It was the view of practitioners and the Review Team that there are few opportunities available to challenge these mindsets. Whilst supervision should be suitably aware of this bias and challenge assumptions, this does not always appear to happen. In addition, it is important that these assumptions are challenged by multi-agency safeguarding partners, and particularly when making decisions about the risks children face. The evidence seen in this case, across the many years of multi-agency involvement, suggests this is not routinely happening. Practitioners and managers spoke about the lack of multi-agency fora that could enable this to happen.

8.4.9 It was understood that a new local in initiative, aimed at facilitating multi-agency discussion and debate, is being taken forward and this looks to be a promising development. However, it is the view of the Review Team that whilst this initiative should be welcomed and supported, the established multi-agency fora and discussions, such as the multi-agency discussions that take place in MASH, strategy discussions/meetings, CIN meetings and CP case conferences, should be premised on a sound foundation of professional curiosity and challenge and, if combined with sufficiently reflective and challenging supervision the dangers of holding a fixed view of a case will be significantly reduced.

**Findings**

The NSCB Thematic Learning Framework from SCR’s appropriately identifies the importance of multi-agency meetings and the need for these meetings to facilitate effective information sharing, discussion and challenge. Introduction of the Signs of Safety Model equips practitioners with the skills, language and tools to facilitate appropriate challenge and in improving multi-agency debate and the recently issued Supervision Policy in Children’s Services (June 2017) clarifies the principles and requirements of effective supervision. Current plans to introduce joint multi-agency supervision is a welcomed development.

**Recommendation 4a**
- Children’s Services to report on evidence of how practitioners are equipped with the skills, language and tools to facilitate appropriate curiosity and challenge in improving multi-agency debate and demonstrate how challenge is embedded in practice.

Recommendation 4b.
- Development of the recent joint multi-agency supervision initiative to be overseen by NSCB to facilitate implementation.

9. **Additional Learning**

9.1 **MASH**

9.1.1 In this case and in previous Norfolk SCRs, several concerns have been identified about the work within the MASH including, but not exclusive to:
- Application of thresholds
- Robust multi-agency decision-making
- Use of anonymous consultation

Recommendation 5
9.1.2 It is understood that MASH has gone through a number of significant changes and the Children’s Services element of MASH is currently under review. It is recommended that the learning from this case, including how family history is used, responding to allegations of physical harm and the advice provided to schools from the MASH is properly considered as part of this current review.

9.2 **Joint decision making**

**Multi-Agency decision making**
9.2.1 Joint decision making after the case moved out of the MASH was largely absent. Overall, information appeared to be properly shared, but decision making was not. There were strong indications that responsibility was passed to Children Services to make decisions, there was no evidence that decisions were ever challenged by the police or that there was any follow up by the police with Children’s
Services or vice versa\textsuperscript{39}. In addition, other involved agencies are not routinely included in immediate and long-term decision-making. This single agency approach on the assessment of risk/decision making about risk dominated the work.

**Child Protection Medicals/ Working Together with Community Paediatrician's**

9.2.2 There were no child protection medicals or health assessments in response to the disclosures made by the children, even when physical injuries were evident. It was the view of the practitioners and managers that this is not unusual in Norfolk, members of the RT confirmed this. In addition, Community Paediatrician's were not involved in any of the strategy discussions.

9.2.3 Paediatric medicals and health assessments can provide important evidence in cases of physical abuse, and most importantly can provide treatment and reassurance to a child where needed. In addition, safeguarding assessments performed by a Community Paediatrician can offer a holistic medical/assessment which are not just about the mark or lack of it but take in the whole history and family events into account and provide a helpful way in which health professionals (such as GP’s) are kept informed about the health and safeguarding needs of children.

**Working in partnership with schools**

9.2.4 Schools were clearly an important safeguarding partner in this case and provided much needed care, support and monitoring of the children’s wellbeing. However, the joint working with schools by MASH and Children’s Services was poor overall and schools were often left to take action in response to serious allegations made by the children in isolation. In addition, there was an absence of challenge and a tendency to adopt a deferential position in relation to the decisions made by MASH or by Children Services, even in circumstances where they felt the decisions would place a child at risk of harm.

\textsuperscript{39} It was understood that a new ‘NFA Strategy’ has been recently implemented in Norfolk Constabulary, where cases that have resulted in No Further Action (NFA) are reviewed and if concerns remain agreement is reached on the continued involvement of the police, this is a welcomed development.
Overall partnership working

9.2.5 These issues have been detailed in a recent SCR in Norfolk:

There was very little pro-active interagency or inter-professional communication or information sharing by any agency before, during or after contacts with the family. Decisions remained uninformed, unchallenged and sometimes not communicated at all. Evidence suggested a general tendency within the partnership to defer to social care decisions without challenge, or to make broad assumptions that colleagues must have done all that needed to be done, or of adopting a ‘fait accompli' attitude. Either way, working in professional isolation is not acceptable for safeguarding work and needs to be rectified.  

Recommendation 6a

9.2.6 In light of the learning in this case the NSCB should review the recent changes made in response to the previous SCR (and the new Norfolk Constabulary ‘NFA Strategy’) to ensure the following is embedded in practice:
- Shared decision-making on risk
- Valuing and using child protection medicals to strengthen the protection of children
- Proactive multi-agency engagement in line with statutory requirements

Recommendation 6b

9.2.6 Multi-agency services should audit and provide evidence of:
- Routine involvement of multi-agency partners in assessments/strategy discussions and any other assessments of risk as they arise.

And that:
- Partners are fully informed of risks and that those professionals who know a child best can inform assessments and contribute effectively to meeting a child’s needs.

9.3 Professional Curiosity and using intuition to safeguard children

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40 NSCR, Child R (2017)
“The intuitive mind is a sacred gift and the rational mind is a faithful servant. We have created a society that honours the servant and has forgotten the gift”

Albert Einstein

9.3.1 In safeguarding work, it could be argued that intuition is regarded with some suspicion, but recent psychological models see intuition simply as a core feature of how our brains work. Intuition occurs when we draw upon our experience to recognise cues in a situation, spot patterns and build a narrative about what is going on, it is simply how our brains use our experience to inform our judgement.

9.3.2 We are constantly using all the available information we have to influence how we communicate with the people we work with, hypothesise about situations and make decisions. Research suggests that experienced practitioners can spot subtle cues and see patterns, and this results in a better understanding of a case.

9.3.3 In this case, practitioners spoke about their intuition- their gut feelings and these gut feelings had the potential of providing vital insight into the family, and the lives of the children. However, practitioners spoke with some hesitancy about using these feelings in their work, were reluctant to mention these feelings in supervision, and would never record them in the case file. Whilst intuition can sometimes send us off in wrong directions in ways that are unhelpful, these errors are predictable and can be guarded against. If explored in an informed and appropriate way (through supervision and case discussion) the use of intuition is a key issue in safeguarding work and researchers caution against the dangers of polarizing between intuitive and analytical decision-making and suggest that both approaches have a role to play in social work practice.

9.3.4 Professional curiosity and use of intuition was evident in this SCR and link back to learning from a previous SCR. Recommendation 1 under the section 8.1 cover the learning in this aspect.

41 O’Sullivan and Helm (2011)
9.4 Listening to Children – Help Seeking Behaviour

9.4.1 In this case, understanding the children’s lived experiences rarely featured in assessments or case recordings across the multi-agency network. Whilst many of the disclosures were recorded, and on occasions were investigated by the police, they were dismissed as unsubstantiated in favour of the accounts provided by Mr. Y. On other occasions, investigations were halted when the children withdrew a disclosure or when the children did not corroborate a disclosure made by a sibling. From the perspective of the children, the overall message they received was that they were not telling the truth.

9.4.2 The behaviour and disclosures made by the children required thinking about beyond the superficial presentation.

9.4.3 As stated by a Review Team member, we often investigate what is said, not why it is said. This is an important distinction. When children make allegations that cannot be proved and are difficult to make sense of, rather than treating it as a disclosure that cannot be substantiated or interpreting a child’s behaviour as attention seeking, the behaviour/allegations would be more helpfully reframed as help seeking behavior and appropriate support provided.

**Recommendation 7**

9.4.3 Listening to children needs to be considered against each of the recommendations made in this report, particularly when developing a practice model.
10. **Summary of recommendations**

10.1 **Recommendation 1:**
NSCB to:

- define and map a practice model, in line with the Signs of Safety approach, for using family history to identify risk and likelihood of sexual abuse, building trusting relationships and platforms for disclosure;
- prevent minimising concerns by encouraging professionals to be descriptive about what they are observing and recording their professional opinions; and
- audit cases to test how widely the model is implemented.

10.2 **Recommendation 2**
NSCB to evaluate the impact of the current CSA strategy across agencies and strategy workstreams in order for progress to be measured. This to include all agencies demonstrating how they disseminate learning form SCRs through the Section 11 process.

10.3 **Recommendation 3**
- 3a. NSCB should ensure that the training Children’s Services commissioned in response to a previous SCR is included in their multi-agency training programme, to broaden the audience and to include links with perpetrators of domestic violence in this training module.
- 3b. All single agency training should include the behavior of perpetrators in their safeguarding training packages.

10.4 **Recommendation 4**
- 4a. Children’s Services to report on evidence of how practitioners are equipped with the skills, language and tools to facilitate appropriate curiosity and challenge in improving multi-agency debate and demonstrate how challenge is embedded in practice.
- 4b. Development of the recent joint multi-agency supervision initiative to be overseen by NSCB to facilitate implementation.
10.5 Recommendation 5
It is understood that MASH has gone through a number of significant changes and it is currently under review. It is recommended that the learning from this case, including how family history is used, responding to allegations of physical harm and the advice provided to schools from the MASH is properly considered as part of this current review.

10.6 Recommendation 6
- 6a In light of the learning in this case the NSCB should review the recent changes made in response to the previous SCR in the following areas:
  o Shared decision-making on risk
  o Valuing and using child protection medicals to strengthen the protection of children
- 6b Children’s Services should audit and provide evidence that:
  o Routine involvement of multi-agency partners in assessments/strategy discussions and any other assessments of risk as they arise,
  o Partners are fully informed of risks and that those professionals who know a child best can inform assessments and contribute effectively to meeting a child’s needs.

10.7 Recommendation 7
Listening to children needs to be considered against each of the recommendations made in this report, particularly when developing a practice model.
Appendix 1

Norfolk Safeguarding Children Board Learning from SCRs:
Key themes and ‘Practice Standards’

October 2016

Background and context

Having undertaken a number of SCRs in the last 5 years, and with a further SCRs at various stages of the review process, it is crucial that the Board makes sense of the learning so we can plan, action and evidence improvement within a clear structure.

The SCR process has developed significantly in this period, including a highly successful action planning session with key partners prior to publication. The outcome of this session was the development of a Thematic Learning Framework, to enable us to think about the recurring issues and barriers to effective working together. This has moved us from a position where we are looking at over 100 individual and sometimes repetitive recommendations to a point where we can think about SMART actions to move us forward on a continuous journey of learning and improvement.

This framework was introduced to Board in December 2015 and has subsequently been tested with partners within Norfolk, through the Public Protection Forum (PPF), with the support of partnership board business managers, as well as nationally.

Thematic Learning Framework

Learning from Serious Case Reviews: Emerging Themes
The thematic learning framework, focuses on four key learning areas:

1. **Professional curiosity** – how can the Board encourage and support appropriate curiosity with families, and between professionals?

2. **Information Sharing and Fora for discussion** – how can the Board ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?

3. **Collaborative Working, Decision making and Planning** – how can the Board improve timely and collaborative planning and get strong and shared decisions?

4. **Leadership: Ownership, Accountability and Management Grip** – how does the Board give effective leadership and champion better safeguarding, locating clear accountability?

At the heart of all learning is the child or young person, understanding their experience and what they expect from the adults in their lives: does this align with the Norfolk vision, i.e. that all children are loved, valued and respected, happy, healthy and safe and have high aspirations for their future? Sitting underneath everything we do is the recognition that safeguarding requires people at all levels to manage risk and uncertainty.

**KEY THEMES:**

The NSCB’s Monitoring & Evaluation Officer has undertaken an extensive analysis of all the recommendations coming out of the SCRs and Multi-Agency Reviews over the past five years. Her findings show that:

- 14 recommendation summary areas occur across more than one SCR
- 8 recommendation summary areas occur across three or more SCRs
- The theme occurring across the highest number of SCRs is
  - Domestic Abuse, followed by
  - Challenge and Escalation (use of the Professional Disagreements Policy)

- Other recommendation summary areas occurring across multiple SCRs are as follows:
  - Information-sharing
  - Returning children home
  - Effectiveness of the SCR process
  - Quality of engagement with children and young people
  - Quality of referrals to CSC and feedback mechanisms
  - Early Help practice
  - Practitioner confidence re CSA
  - Achieving Best Evidence
  - Neglect
  - Core standards for supervision
  - Use of historical information in assessments

These findings have been presented to SCRG and PPF. The central premise is that all learning is child centred and we need to be anchored to the premise that we are
working to get the best outcomes for children: remembering what it is like to be a child in Norfolk and asking ourselves what can and should they expect from the adults in their lives who should be keeping them safe.

More specifically, under each of the four quadrants we have started developing headline outcomes that we need to work towards to assure ourselves that Norfolk safeguarding arrangements are co-ordinated and effective. We propose to use this framework to review our approach to practice standards, with reference to our Threshold Guide and multi-agency commitment to working within the Signs of Safety framework. NB this work is still in development.

**Practice Standards: Outcomes & Evidence Expected**

**1. PROFESSIONAL CURIOSITY AND PRACTICE**

1.1 Practice is child centred and recognises the children and young people we work with as unique individuals

1.2 Multi-agency assessments are analytical, of a high quality, and make full use of all the child/family’s history

1.3 Parents and carers, including less visible parents, are fully involved with safeguarding and child protection processes, and issues of PR and consent are routinely explored

1.4 The workforce is highly skilled and trained to recognise, address and challenge disguised compliance

1.5 Practice takes account of the impact of different types of abuse, both emotional and physical, and addresses the needs of the child

**2. INFORMATION-SHARING AND FORA FOR DISCUSSION**

2.1 Engagement with children and young people is effective and professionals build positive relationships with children and young people, helping them to feel safe

2.2 Norfolk has effective systems in place to track concerns within agencies, records include all relevant information and all relevant information is shared between agencies, with a particular focus on Domestic Abuse

2.3 Appropriate professionals are engaged in decision-making within the Multi-Agency Safeguarding Hub and other multi-agency discussions, in particular health partners

2.4 Information recorded in assessments and agency records is high quality and shared with children, family and the multi-agency partnership in a timely manner

2.5 Practitioners from all agencies understand the difference between consultations and referrals, and feel confident in making referrals to the MASH. Feedback on referrals is provided in a timely way

**3. COLLABORATIVE WORKING AND DECISION-MAKING**

3.1 Professionals are confident to challenge one another and be challenged within the multi-agency arena in order to achieve the best outcomes for the child
3.2 Norfolk applies consistent thresholds and there is a clear rationale in each case for why decisions have been made, leading to appropriate and timely referrals for intervention.

3.3 Significant case decisions in respect of safeguarding are made jointly across agencies and supported by multi-agency planning to best meet the needs of the child.

3.4 Norfolk’s Early Help offer is well established and includes robust mechanisms for proactive review and challenge to ensure cases do not drift.

4. **OWNERSHIP & ACCOUNTABILITY: POLICY, PROCEDURE & GUIDANCE**

4.1 All agencies understand and follow national guidance in relation to information sharing when working with children and families.

4.2 Practice standards for Early Help are in place and QA systems are used routinely to ensure the quality of the FSP process.

4.3 Staff supervision is of a high quality and provided to all frontline staff working with children and families.

4.4 Practitioners and managers are able to confidently exercise sound professional judgement in order to safeguard vulnerable children and young people.

4.5 Policies and procedures are in place to support all staff in achieving positive outcomes for children, specifically in relation to Domestic Abuse and Neglect.

**Ownership and accountability: commissioning and gaps**

5.1 Practitioners and managers have access to specialist advice and services when working with complex cases (including CSA).

**Ownership and accountability: NSCB monitoring and scrutiny**

6.1 All agencies are aware of, promote and follow NSCB policies, with a specific focus on Professional Disagreements, Disclosure Protocol and Working with Reluctant and Hostile families.

6.2 Practitioners are confident when working with cases where neglect, sexual abuse and/or domestic abuse are present, including at the Early Help stage.

6.3 Robust processes and arrangements are in place to ensure that the actions from SCRs are completed and that learning is shared and embedded across the children’s workforce.
Appendix 2: Feedback from participants - Case Y – Learning Event
12 feedback forms received

1) What did you think about the pre-event information you were given?

- It was comprehensive, I knew why the event was being held and felt prepared – 10 people ticked this box
- It was adequate, I knew what the event was but not the reason behind it – 1 person ticked this box
- It was poor, it did not tell me what I wanted to know – 1 person ticked this box.

2) Please describe your feelings prior to this event and why you felt this way?

- Worried about doing the children justice. Hopeful that the children were safe and getting care/love they need.
- Anxious about how the event would be delivered and about being able to feel contained emotionally.
- Anxious, reflective and nervous.
- I felt ok about the session after my one to one interview.
- Hopeful that we have an opportunity to take significant learning from this SCR.
- As part of Panel interested to meet those involved with their care. Difficult case.
- Overwhelmed by the amount of undetected abuse and physical abuse and complexity of the case. Hopeful for learning to share with my team to increase awareness.
- Slightly apprehensive about attending as I am new to the area and very aware that I was not involved/not met the children.
- Apprehensive, concerned that there may be a blame element.

3) Did you find this day useful? YES / NO

12 people answered Yes

Please explain your answer

- So impressed by the people working with the children – commitment to learning so that “we” are better equipped and able to support and protect other children suffering CSA.
- It made me feel hopeful that we can continue to make changes to keep children safe. It was lovely to see some of the professionals that worked with the case and to know how the SCR process has supported the children.
- The case has been something that will sit with me, for a good reason as I am and continue to be privileged and blessed to have met the children and worked alongside them.
- Having open conversations throughout the day.
- I felt this was an open and honest conversation that helped constructive discussion and provided clear recommendations.
- Really hopeful to have open discussions between agencies reorganising the challenges for everyone. Understanding how it made people feel.
- Lots of issues discussed.
- Very useful. Very powerful to see the emotional impact and commitment of professionals but also hear the children’s stories.
- Insight into all agencies involvement and learning from case from multi-agency perspective.

4) What was the key piece of learning that you have taken from today?
- Need to professionally challenge when we are not happy with decisions.
- That multi-agency information sharing is absolutely central. Supervision and management oversight to help practitioners think the unthinkable/hypothesise. Need to have open conversations re CSA. Need to talk about it! Rule it out, not in!
- To be curious and listen to your ‘gut’.
- Having courageous conversations at the right time. Predominantly to continue to be curious and keep the child at the focus of every observation.
- Having confidence to have brave conversations.
- The need for open conversations, confidence to respectfully challenge and to work with multiple – hypothesis is still a key area that needs to be tackled.
- Insight into improvements that need to be made in different areas.
- Children find it hard to tell – need to listen and change our response and take them seriously. Also reorganised the impact of telling has had on the family – think hard about what their behaviour is telling us.
- Listen to children,
- Serious Case Reviews are challenging but that there are key issues coming out that need to be remembered when you are working with families. Pedophiles are very manipulative and appear very plausible.
- The voice of the child and not missing opportunities. Power of perpetrators and disguised compliance.
- Child’s voice is still not being heard. Professional curiosity is still not consistent. Theme that all agencies want to learn from this.

5) How will you implement this in your day to day practice?
- Training, supervision, workshops and meetings.
- Quality supervision focusing on the voice of child. Trying to see life from child’s perspective and work with health professionals to identify this.
- We need to open up dialogue about sexual abuse more readily than we do. I will be presenting to my team at next team meeting.
- Continue to listen to children and refer when appropriate.
- Think about our assessments – how as a paediatrician I can listen to what children are saying and remember not to let the parent’s voice be louder than the child – but think and balance what we hear.
- Continue to remain vigilant in our safeguarding procedures.
- Continue in the getting to good working and bring in lessons from SCR especially re professional curiosity and the child’s voice and lived experience.
- The learning has already been implemented in practice. More open conversations.
- I have already begun to implement in my observations and share with TM/SW around how I feel when I meet a child and family for the first time.
- Be aware of my instincts, and acknowledge them.
- Commission/participate in staff training on CSA. Support Norfolk CSA sub-group to move leaflet/work forward.
- Discussion with DSLs about challenge.

6) Has this highlighted any additional training need for you?  YES / NO

1 person answered No
10 people answered Yes
1 person did not answer

If yes, please detail

- CSA – Modus Operandi of perpetrators, recognising CSA, co-existing abuse.
- Contained CSA training for multi-agency professionals.
- I feel that I need to look out for sexual abuse training as a refresher, looking back through course information that I have previously attended.
- Training
- The CSA training – understanding the perpetrator.
- Would be interested in any training around CSA or prolific abuse in families.
- Professionals will always need on-going training with regards to identifying CSA and encouraging disclosure.
- Multi-agency training on perpetrators.
- How to work with children to provide a safe platform for them to disclose sexual abuse, more open dialogue between agencies.

7) Now the day has finished, how do you feel about this process?

- I felt this was very helpful for practitioners who were involved in the case and with the children. Supportive informative process.
- Emotional. Determined to implement learning.
- Good opportunity to listen to one another.
- Reasonably informed but very aware of the many ‘gaps’ in the system.
- Relieved and pleased that I can attempt to move on from this particular case but at the same time hold onto the learning moving forward.
- Reassured and amazed at the level of care and thoughtfulness taken.
- Better
- That I would be able to support someone else through the sessions.
- Pleased and hopeful of change.
- Better informed.
- Very productive.

8) Would you recommend to others that they attend a day like this?  YES / NO

12 people answered Yes

Please explain your answer

- Valuable reflective experience.
- Informative, good multi-agency commitment and supportive.
- Vital learning day to reflection case and to try to prevent similar cases happening in future or be aware of abuse earlier on.
- Good insight into learning lessons from cases like this.
- Really important – we should do this more often – not for SCR but for more cases.
- This is very relevant for learning and sharing views from professionals.
- Multi-agency working means multi-agency learning and this event helps to drive that message home – systemic thinking/working.
- Being able to discuss learning with professionals who know the children well really helped to hammer home the learning.
- For the learning and interaction with other agencies, having the time to explore this very sensitive issue away from work.