Norfolk Safeguarding Children Board

Learning from Serious Case Reviews

Case Y

Serious Case Review: Case Y

This presentation sets out:

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

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

- Six children ranging from between 4- 16 years at time of disclosures of sexual abuse from three of the children
- Lived at home with their father – a single parent
- Various health needs, difficulties with learning and peer relationships
- Father – a history of alcohol and drug misuse, domestic violence and allegations of sexual assault
- Mother – a history of difficulties in parenting her children
- Transient family (in the children's early years)

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

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

- Multi-agency involvement since the birth of the youngest child

- Children in receipt of services from Children's Social Care, schools and a variety of health professionals at the time of disclosure

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Serious Case Review: Case Y Methodology

Scope of review is between July 2015 (12 months prior to disclosure leading to removal) and September 2016.

Agencies involved were:

- Norfolk Constabulary
- Education Advisory Service
- Clinical Commissioning Group
- Community Health and Care NHS Trust
- Children's Services

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Serious Case Review: Case Y Methodology, cont.

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

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

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Case Y: Background information – pre 2015

Father : historic allegations of rape x 2 and sexual assault : one male, a 12 year old girl and another young female

“Prolific” history of violent and controlling behaviour perpetrated by father, drug and alcohol misuse, maternal depression and fear of father

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Case Y: Background information, cont.

History of children being the subject of CP plans for neglect and emotional abuse, non accidental injuries and an 18 month period in foster care (4 eldest) in another Local Authority

Also in early childhood:

- concerns about the behaviour of the 2 boys when in the care of parents,
- “absences”(youngest girl),
- peer relationships
- self esteem,
- domestic violence and parental association with unsuitable adults

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Case Y: Background information, cont.

Family moved to Norfolk in 2012.

Between June 2012 and July 2016 there were 26 allegations of physical / sexual abuse reported to services by mother, family members, household visitors, anonymous referrers and the children

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Case Y: July 2015 – Sept 2016

Sibling 5 (6 years) and Sibling 6 (3 years)

- **April 2015:** Sibling 5 discloses father's physical violence at school which the school refer to MASH. Advice given to speak to father. This sets a concerning precedent.

- **July 2015:** GP involvement: conducts full body examination during routine appointment, noting bruises and small abrasions. Father explanation of boy as very active accepted.

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Case Y: July 2015 – Sept 2016, continued

July 2015: Section 37 report

- Mum applies to court for contact, reporting concerns about her ex-partner's violent behavior and history of abuse.
- Court order made to Children's Services to submit a Section 37 report, assessing the parenting capacity.
- Report failed to:
  - Seek or include info from school re Sibling 5's disclosure of physical violence three months earlier
  - Account clearly for the children: names were muddled and it was clear they had not been seen alone
  - Involve mother with the assessment: her information regarding her husband's abusive behavior was not recorded in the report that went to court

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Case Y: July 2015 – Sept 2016, continued

The S37 report submitted to court:

- stated that there were no concerns about paternal care
- concluded that the children did not wish to see their mother
- 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.

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Case Y: July 2015 – Sept 2016, continued

Ongoing disclosures of physical abuse and mental health issues resulted in peripheral involvement with police and health as single agencies.

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."***

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"*.**

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Case Y: July 2015 – Sept 2016, continued

Both the primary and secondary schools had ongoing concerns.

May 2016: A family friend contacted the school to report concerns about physical abuse. The children confirmed this with the school Safeguarding Manager. 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.

All the children spent the night with the family friend while the case was passed to the Children's Services assessment team for completion of a S47 investigation.

Case Y: July 2015 – Sept 2016, continued

- The following day the father was interviewed by police. He explained the physical abuse as ‘play fighting’ or a response to their naughty behaviour.

- He was given two conditional cautions for common assault with conditions that he comply with treatment for his alcohol misuse, and fully engaged with Children’s Services.

- Social work assessment commenced with a management direction not to include the views of Mrs Y with reference to the Section 37 report

- The 5 younger children were returned to their father’s care; the eldest remained with the friend.

Case Y: July 2015 – Sept 2016, continued

- The assessment included the involvement of an Assistant Practitioner who completed a Signs of Safety mapping exercise with all the children. Her gut feeling was that *"something was not quite right".* This feeling was shared by the allocated Social Worker.

- 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.

- The case was passed to the Family Intervention Team under S17, Child in Need.

Case Y: July 2015 – Sept 2016, continued

- Newly allocated staff reviewed the case history resulting in a renewed focus and urgency to the services provided

- Under S17 a Home-Based Support (HBS) practitioner visited the family home. 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 following week Sibling 4 disclosed to the school Safeguarding Manager.

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Case Y: July 2015 – Sept 2016, continued

- An immediate strategy meeting was held and police interviewed the children.
- 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.

Case Y Terms of Reference: Research Questions

- 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?

- 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?

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

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Case Y: TOR 1
Learning from this SCR

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?

Learning from this SCR focuses on:

- The importance of history
- Likelihood – the balance of probability
- Use of terminology
- Building trusting relationships
- Building ‘a platform for disclosure’

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Case Y
TOR1: findings and recommendations

The NSCB are encouraged to draw on the learning from this SCR, particularly around using clear, open and accurate language to prevent minimising concerns and demonstrate professional curiosity.

Recommendation 1: The NSCB to:

- define and map a practice model, aligned with Signs of Safety 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

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Case Y: TOR 2
Learning from 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?

Learning from this SCR focuses on:

- The work of NSCB
- Evidence of good awareness
- Commitment to raising awareness, training and staff development
- Dissemination not consistent across agencies

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Case Y
TOR2: findings and recommendations

The Board has taken a pro-active response to prevention, identification and interventions required to better tackle Child Sexual Abuse (CSA) as result of learning from previous SCRs.

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.

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Case Y: TOR 3
Learning from this SCR

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

Learning from this SCR focuses on:

- Understanding perpetrators
- Understanding Domestic Violence
- Curiosity and challenge

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Case Y
TOR3: findings and recommendations

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

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Case Y
TOR3: recommendations, cont.

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.

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Case Y: TOR 4
Learning from this SCR

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

Learning from this SCR focuses on:

- A fixed view of a case
- The importance of supervision, curiosity and challenge
- The value of multi-agency meetings and decision making

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Case Y
TOR4: 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 welcome development.

Case Y
TOR4: recommendations

Recommendation 4a

- Children's Services to report on evidence demonstrating 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.

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Case Y
Additional Learning

MASH

- Application of thresholds
- Robust multi-agency decision-making
- Use of anonymous consultation

Recommendation 5: It is understood that MASH has gone through a number of significant changes and the Children's Services element 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.

Case Y
Additional Learning, cont.

Multi-agency work

- Joint decision making
- Child Protection Medicals
- Working with schools

Recommendation 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:

- 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

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Case Y
Additional Learning, cont.

Recommendation 6b

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.

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Case Y
Additional Learning, cont.

Listening to Children – Help Seeking Behaviour

<u>Recommendation 7:</u> Listening to children needs to be considered against each of the recommendations made in this report, particularly when developing a practice model.

In the words of the child who disclosed:

"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]"

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

- Norfolk is currently in the second phase of the England Innovation Project and is working towards further embedding the Signs of Safety approach which will take into account the learning from this SCR. This includes auditing practice.
- The steering group responsible for implementing the CSA Strategy will continue to monitor and report on the impact of training and awareness raising on practice. Actions to date have included:
  - The development and promotion of a CSA awareness raising leaflet, in partnership with Norwich City Football Club
  - A comprehensive resource library on the NSCB website
  - A two day conference on the impact of CSA held in Nov 2017

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

- The NSCB multi-agency training programme will include more training on understanding perpetrators of CSA from 2018 – 19.

- The Section 11 challenge days will focus on CSA, training and learning from SCRs

- Following the Ofsted inspection of Children's Services, published January 2018, all partners have committed to reviewing the function and impact of the MASH

- SCR roadshows planned to disseminate learning and general themes from this and other SCRs in spring 2018

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