Norfolk Safeguarding Children Board

SERIOUS CASE REVIEW

FAMILY U

Executive Summary

Independent Author: Sian Griffiths

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1. INTRODUCTION

1.1 The circumstances that led to undertaking this Review

1.1.1 In October 2015 an 11-year-old child, Sibling 2, who had very recently been placed in Foster Care by the Local Authority, made disclosures that she and three of her siblings had been seriously sexually abused by her father over several years. All 4 children's safety was secured within 24 hours and Care Proceedings were subsequently initiated and the children made subject to Care Orders.

1.1.2 The father subsequently received a life sentence with a minimum tariff of 16 years for a number of sexual offences. The mother pleaded guilty to an offence of child maltreatment and was sentenced to 2 years imprisonment. An older Sibling also pleaded guilty to a sexual offence with a child and received a 2-year Suspended Sentence with a Supervision Order.

1.1.3 Statutory guidance as laid out in Working Together 2015 requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews when a child dies or is significantly harmed and there is cause for concern about abuse and the services provided by any agencies. The Norfolk Safeguarding Children Board concluded that a Serious Case Review should be commissioned in relation to the 4 siblings and this was published in April 2017 after the completion of the criminal proceedings. The full Serious Case Review can be seen at. (web address here).

1.2 Methodology

1.2.1. The methodology used for this Review was underpinned by the principles outlined in Working Together, including the need to use a systems approach. This involved: a full chronology and individual reports from the key agencies involved with the family; access to primary documentation; meetings with more than 20 professionals, individually and as a group; meetings with a review team of senior safeguarding leads and managers from the key agencies:

- Cambridgeshire Community Services NHS Trust (Health Visiting services)
- Norfolk Community Health and Care (Health Visiting and Community Services)
- Norfolk County Council Children's Services
- Norfolk County Council Education
- Norfolk Constabulary
- Norfolk and Norwich University Hospital Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Great Yarmouth and Waveney Clinical Commissioning Group (in relation to General Practice)

1.2.2. The Independent Reviewer also met with members of the family, that is the mother, father, maternal grandmother, an older sibling and two of the siblings who are subject to this review. The author is very grateful for their contribution.

1.2.3. The timeframe under consideration for this Review was:

January 2005 – October 2015

However, the primary period for consideration was January 2012-October 2015**.** Four particular areas for learning were identified for consideration:

1. *What does this review tell us about the effectiveness of the multi-agency safeguarding partnership, particularly when working under thresholds of statutory social care intervention? This will include challenge around thresholds for intervention and fora for discussion and information sharing.*
2. *How do professionals and agencies working with large families understand the needs of the individual children in the context of the whole family?*
3. *How do we work with children so that they feel safe to talk about or otherwise express their feelings in order to enable professionals to make sense of what they are seeing and hearing?*
4. *What does this case tell us about professionals' and agencies' level of confidence in identifying and working with different types of child abuse, including sexual abuse and neglect?*

2 SUMMARY OF THE CASE AND AGENCIES' INVOLVEMENT WITH THE FAMILY

2.1. The four children subject to this review were part of a larger family all of whom had lived, or were living, with their mother in the family home. The three youngest children's father, who was subsequently convicted of the sexual abuse, had lived for a period in the family home. For the latter years he lived elsewhere but continued to have significant contact with the children.

2.2. The family had involvement with a very high number of agencies as a result of concerns about the children's welfare over a period of years. These concerns included very poor school attendance, home conditions, and problematic behaviours, including aggressive behaviour by one of the children, children going missing and self-harm. All of the children were identified by the parents, as having a range of underlying problems such as ADHD or learning needs, most particularly Sibling 2, who was viewed as having the most difficult behaviour. Formal diagnoses by medical professionals were also made for some of these conditions. The mother had also experienced a serious health condition, and her health was considered to be an explanation of some of the difficulties. The father had a history of mental health problems and had himself experienced abuse from his own

father. There were some allegations of sexual assault by different children, but these never led to any formal action. In the later years there were concerns that the oldest of the 4 siblings was at risk of Child Sexual Exploitation.

2.3. There had been occasional involvement of Children's Services with family members prior to 2012, but this had not progressed beyond assessment. From 2011 there were periods when the children were subject to a CAF (Common Assessment Framework), the multi-agency approach taken when children have additional needs that do not meet the threshold for Child Protection or Care Proceedings. In 2013 an assessment by Children's Services resulted in the children being identified as 'Child in Need' and as a result becoming subject to multi-agency planning led by Children's Services. By April 2014 the situation in the family had worsened further and there were discussions about potential foster placements for the two older children. However, it was not until the summer of 2015 that the oldest, Sibling 1, was placed in foster care, and a few months later that the second oldest, Sibling 2, was also placed in foster care. Within weeks of moving into foster care Sibling 2 made the disclosure of sexual abuse that ultimately resulted in the criminal convictions.

3. APPRAISAL OF PRACTICE AND ANALYSIS

3.1. A number of specific episodes of agency practice were identified in the Review, not least in relation to failures by the Police and Children's Services to properly investigate allegations of sexual assault. Given the very significant passage of time and the major changes in organisational structures these were not subject to recommendations in this Review. The Review focussed primarily on those features of practice that would contribute to current and future learning.

3.2. The overall conclusion of the Review was that:

- Although the different agencies and professionals involved with the family were undoubtedly concerned about the children and recognised that they were experiencing neglect, they did not adequately recognise symptoms that could have indicated sexual abuse within the family.

- Whilst there was a high degree of agency intervention it took considerably too long for decisive action to safeguard the children to be initiated.

3.3. The Review identified a complex range of factors that contributed to this situation including:

- Lack of adequate understanding and assessment of the adults in the family, their individual histories and their capacity or willingness to make the changes that were needed.
- A pattern within the family of explaining the children's behaviour as being a result of 'medical' diagnoses, such as ADHD, and a lack of challenge to this as an explanation.

- The amount of problems presented by the family having an overwhelming effect on agencies who were attempting to help or manage these problems.
- Symptoms of sexual abuse being explained as a result of a child's 'diagnosis' or believed to be related to poor parental boundaries.
- A lack of confidence for some in either identifying or in 'naming' sexual abuse.
- Absence of proper review of the family situation based on a good understanding of the history.
- Lack of overview of the agency activity and its impact for the children.
- Pressures on agency resources, particularly in Children's Services, contributing to adequate reflection and analysis about the family situation.
- A Priority within Children's Services on reducing the numbers of Looked After Children making it difficult to move children into Child protection or Care.

4. LEARNING AND RECOMMENDATIONS

4.1 The individual agencies identified a number of agency specific learning points which are laid out in detail in the full SCR.

4.2 A number of learning points for practice were also identified, reflecting the factors identified in Section 2:

- Children need to feel safe before they can disclose that they are being sexually abused.
- Reliance should not be placed on children verbally disclosing sexual abuse.
- Confidence in recognising and naming sexual abuse as a potential concern must be developed across the workforce if children are to be protected.
- Relationship building is particularly significant when working with adolescents.
- 'Medical diagnoses' and other parental concerns can act as powerful smokescreens distracting from children's underlying problems.
- Active engagement with and assessment of fathers or other men in a family should be considered as routine.
- Child Sexual Abuse may be 'hidden' behind neglect and there may be links between the two.
- Understanding of the parenting capacity of all those involved in caring for children in a family is fundamental to assessment of their needs and any risks to them.
- Full and up to date chronologies are key to good assessment.
- Regular review is crucial in order to avoid drift.
- Practitioners need to remain alert to the impact of the emotional content of working in complex safeguarding situations on capacity to focus on the child and maintain critical thinking.

4.3. Having taken into account the changes in practice that have already taken place the following 4 recommendations were made to the Safeguarding Children Board:

Recommendation 1

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

Recommendation 2

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

Recommendation 3

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

Recommendation 4

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